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ABSTRACT

This report is the fourth in a series of follow-up analyses of nine longitudinal studies addressing the costs and effectiveness of alternative types of early intervention for children with disabilities. An introduction provides an historical perspective and conceptual framework for the studies, including common study elements and how research sites were selected. Focus of the studies has been on effects of varying the intensity of the intervention, effects of beginning intervention at different ages, and effects of variation in program components. A summary is provided for each study consisting of, first, information about the alternative forms of intervention being examined, and, second, a graphic summary of the outcomes for the various measures of child and family functioning. The bulk of the report consists of individual site reports in which each include a rationale, methodology, results and discussion, and conclusions. The individual studies are: (1) the New Orleans Visual Impairment Study (which varied the intensity of family involvement); (2) the SMA/LakeMcHenry Intensity Study (which varied the frequency of intervention services); (3) the Arkansas Intensity Study (which varied the frequency of home-based interventions by paraprofessionals); (4) the Jordan School District (which varied the frequency of a center-based intervention and the adult/child ratio); (5) the Salt Lake City Medically Fragile Study (which varied the age at which sensorimotor intervention was begun); (6) the Charleston, South Carolina Medically Fragile Study (which also varied the age of beginning intervention); (7) the Columbus Medically Fragile Study (which varied the intensity of intervention); (8) the Des Moines Public Schools Study (which compared center-based interventions with and without a parent education component); and (9) the Utah Parent Involvement Study (1986) (which also compared center-based interventions with and without a parent education component).

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ANNUAL REPORT FOR PROJECT PERIOD

OCTOBER 1, 1993 - SEPTEMBER 30, 1994

of the

Longitudinal Studies of the Effects of Alternative Types of Early Intervention for Children with Disabilities

Submitted to the

U.S. Department of Education

by the

Early Intervention Research Institute

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PREFACE

This document contains the fourth report of the **Longitudinal Studies of the Effects and Costs of Alternative Types of Early Intervention for Children with Disabilities.** These studies are a follow-up of research that was conducted from 1985 to 1990 by the Early Intervention Research Institute (EIRI) at Utah State University as a part of a contract (Contract #300-85-0173) with the United States Department of Education. Funding for that project was provided by the U. S. Department of Education as well as the National Institute of Child Health and Human Development and the Office of Maternal and Child Health of the Public Health Service. The original project on which this follow-up research is based began enrolling subjects in 16 different studies in October of 1986. Data were collected for subjects in those 16 studies through the Fall of 1990. At that time, another contract was funded by the Department of Education (Contract #HS90010001) to continue data collection for 9 of the original 16 studies for an additional 5 years.

These studies reported in this document will continue data collection activities through 1995. Although most of the results reported in this document will not change significantly as a result of continued data collection, the additional information to be obtained may impact on the interpretation of results and on the importance ascribed to results on data collected earlier. The reader must remember that additional data are being collected and analyses continue with already available data, and that these may impact on the specific study being read. As work continues, more up-to-date information will be available from the Early Intervention Research Institute.

Staff members contributing to sections of this report included: Glenna Boyce, Diane Behl, Glendon Casto, Michael Godfrey, Mark Innocenti, Conway Saylor, Matthew Taylor, and Karl White. Preparation of the report was done by Mary Ellen Heiner and Irene Welch.

Longitudinal Studies of the Effects of Alternative Types of Early Intervention for Children with Disabilities

INTRODUCTION

In 1985, the U.S. Department of Education funded a series of studies designed to evaluate the effects and costs of alternative types of early intervention programs for children with disabilities. The impetus for this type of a large scale research project came from at least three sources. First, since the early 1960s, hundreds of research studies had been conducted to investigate the efficacy of early intervention programs for children who had disabilities, were disadvantaged, or were at risk. Unfortunately, much of this research, particularly that done with children who have disabilities, suffered from serious methodological flaws, narrow definition of outcomes, and/or inadequately implemented interventions (Dunst & Rheingrover, 1981; Farran, 1990; Simeonsson, Cooper, & Scheiner, 1982). The best research, from a methodological perspective, had been done with children who were disadvantaged, but legitimate concerns were expressed about the degree to which findings from research with such children should be used to make decisions about programs for children with disabilities (White & Casto, 1985).

Second, a series of federal laws were enacted during the 1970s and 1980s which mandated services for children with disabilities. The first bill, Public Law 94-142, mandated services for all school-age children with disabilities; the second, Public Law 99-457, established an important and historical extension of P.L. 94-142. The greatest changes were those that mandated services for preschool-aged children with disabilities and in the establishment of Part H of P.L. 99-457. Part H of the law provided substantial incentives for states to establish services for children under age three. Under Part H, the family became the focus for intervention activities rather than the child alone. Education-related services were no longer the primary focus, and professionals, other than educators, could take a lead role in intervention. Children deemed at-risk, at state option, became eligible for services.

Third, since the early 1980s, resources for providing human service programs have become increasingly limited. This has led policy makers and program administrators to be more concerned about the costs as well as the effects of all human service programs. With regard to early intervention, there have been increasingly frequent questions about which types of programs are most cost-effective. Unfortunately, as noted by Barnett and Escobar (1987), very little previous early intervention research has included a defensible cost-analysis component.

It was in the context of these three factors: (a) limited high-quality early intervention research for children with disabilities; (b) pressures to expand early intervention programs for children with disabilities; and (c) the almost total absence of efficacy research which included a cost-analysis component, that the U.S. Department of Education issued a Request for Proposals (RFP) in the Spring of 1985. This RFP called for a contractor to conduct a series of experimental studies investigating the effects and costs of alternative types of early intervention for children with disabilities. The RFP stipulated that each study: (a) must be a randomized experiment in which two alternative types of intervention were compared; (b) must consider the effects of the intervention for both children and families; (c) must analyze the costs of the alternative types of intervention in conjunction with the effects; and (d) must be carried out in field-based settings which were representative of state-of-the-art early intervention programs.

Additionally, the RFP required three types of studies to be done: (a) some investigating the effects of varying the intensity of the intervention program; (b) some investigating the effects of varying the age at which the intervention program began; and (c) some investigating the effects of program variation. These studies were to include children with disabilities of different types (e.g., children with visual impairments, children with severe disabilities, and children who were medically fragile), instead of children who were disadvantaged or at risk. The contract provided funding for an initial 5-year period so that the effects of intervention could be assessed longitudinally, but the money was limited to actually conducting the research and was not to be used to fund the intervention programs. Utah State University was awarded the contract to conduct this series of longitudinal studies.

This set of studies was initiated in October of 1985 and was referred to as the *Longitudinal Studies of the Effects and Costs of Early Intervention with Handicapped Children*. The results of the 16 studies conducted by this institute are available in a final report to the government (ERIC Document # ED 202 089). During the final year of this institute, the U.S. Department of Education issued a competitively bid RFP to continue 9 of the original 16 studies. Utah State University was awarded the contract for the *Longitudinal Studies of the Effects and Costs of Early Intervention for Children with Disabilities: Follow-up Institute* (Contract #HS90010001). The purpose of this report is to present these nine studies in detail. As these studies are longitudinal, information since these studies were initiated are included in this report.

The purpose of this section of the report is to summarize the historical factors which led to the initiation of the studies, provide a conceptual framework for the studies, describe the issues which were addressed by the studies, outline the basic research designs, provide a rationale and description of the instrumentation, and summarize the procedures used to ensure that the treatments were implemented as planned. This section of the report discusses the relevance of the information presented (on studies initiated nine years ago) to early intervention practice today. Finally, this section presents information on current institute activities in regard to these studies and a brief summary of the nine studies.

HISTORICAL PERSPECTIVE

The significance of the studies conducted as a part of this initiative can be understood better if they are placed in an historical perspective. In the 1930s and 1940s, there was much interest in the heritability and alterability of intelligence. Howard Skeels was one of the principal figures in this argument. His research demonstrated the cumulative effects of inadequate home environment on the intelligence of children (Skeels & Fillmore, 1937), and the positive effects of altering such environments during the preschool years (Skeels, Updegroff, Wellman, & Williams, 1938). His studies were heavily criticized, and he was not vindicated until he published a monograph in 1965 (Skeels, 1965) which detailed the adult status of his 125 original subjects. The data reported in this monograph supported his position that nurture was as important as nature in human development, and, along with a landmark book by Hunt (1961), justified the potential importance of early intervention.

Early intervention programs for both children who were disadvantaged and those with disabilities began in earnest during the 1960s. The first proposal for a public compensatory education program came from the President's Panel on Mental Retardation in 1962. Head Start programs began in 1965, and the first Handicapped Children's Early Education Programs (now Early Education Program for Children with Disabilities [EEPCD]) were established in 1968.

An initial evaluation of the Head Start program (Cicirelli, 1969) produced results which many interpreted as showing that initial gains in Head Start were largely "washed out" by third grade. These findings temporarily slowed the forward momentum of early intervention advocates. However, subsequent findings from other early intervention studies with children from disadvantaged backgrounds (e.g., Gordon, Guinagh, & Jester, 1977; Gray, Ramsey, & Klaus, 1982; Karnes, Hodgins, & Teska, 1969; Levenstein, 1970) regenerated the enthusiasm for the benefits of early intervention.

In the 1980s, the Consortium for Longitudinal Studies (Lazar, Darlington, Murray, Royce, & Snipper, 1982) provided what many believed to be definitive evidence that early intervention with children who were disadvantaged had substantial long-term effects. This perception was subsequently buttressed by long-term results from the Perry Preschool Project (Berrueta-Clement, Schweinhart, Barnett, Epstein, & Weikart, 1984) and the results from the Abecedarian Project (Ramey & Haskins, 1981). Many people assumed that these studies had answered questions concerning the efficacy of early intervention once and for all.

However, it was not long before researchers began questioning the use of data from the disadvantaged populations to draw conclusions about the effects of early intervention for children with disabilities. A growing number of researchers also questioned the methodological quality of the available data for children with disabilities (Bricker, Bailey, & Bruder, 1984; Dunst & Rheingrover, 1981, Simmeonson et al., 1982; White & Casto, 1985). The following quotations summarize these researchers' growing concerns.

> The large majority of studies...do not provide the type of evidence needed to support the contention that early intervention is efficacious with organically impaired children. It should be made explicit that we are not concluding that early intervention does not work. Rather, we are concluding that flaws in the experimental designs employed make most of the results from most of the studies uninterpretable from a scientific point of view (Dunst & Rheingrover, 1981, pp. 318).

> Overall, a limited number of studies met common criteria for scientific research. Inadequate specification of inclusion criteria characterized half of the studies. The lack of adequate descriptions of inclusion criteria places limitations on any generalization of the findings. Random assignment in the use of control or contrast groups is characteristic of less than one fifth of the studies. (Simeonsson et al., 1982, p. 638)

It was in this context that the U.S. Department of Education issued the RFP for conducting a series of longitudinal studies to investigate the effects and costs of alternate types of early intervention. The studies were designed to increase the knowledge base regarding certain parameters of intervention for children with disabilities, with the goal in mind of improving current service programs, providing information about the cost-effectiveness of various intervention alternatives, and demonstrating the feasibility and value of conducting experimental longitudinal research in collaboration with typical service providers.

CONCEPTUAL FRAMEWORK

The general approach taken in designing and conducting the set of longitudinal studies described here can best be understood using the framework of general systems theory (Bandura, 1977; Bronfenbrenner, 1977; Sameroff & Chandler, 1975; Ramey, McPhee, & Yeates, 1982). Our interpretation of general systems theory is based on the following organizing principles:

(a) The developing infant is the product of a variety of "systems" (e.g., immediate family, neighborhood, school) which are in constant interaction with each other. Each system functions at a variety of levels. Complex interactions occur within and across levels, as well as between systems.

(b) Development is characterized by plasticity and self-righting tendencies. The genetic potential of the infant or toddler with disabilities interacts with the environment to produce developmental changes. From this perspective, one would hypothesize that the same early intervention program would have different effects for different children based on genetic potential, degree of disability, the nature of the family, and the larger environment. Thus, plasticity in development and the child's self-righting capabilities play a significant role in intervention outcomes. It also suggests the need for considering individual differences in development.

(c) In maximizing developmental potential, both hereditary and environmental factors are important. Since, at the present time, we have limited control over genetic potential, resources available for early intervention should be used to produce optimal intervention environments. After birth, such optimal environments would include a family system which can assist the child, and an intervention system which is responsive to both child and family.

(d) The birth of an infant with disabilities impacts substantially on two interrelated systems. First, the primary system (the child) must attempt to gain equilibrium; and second, the larger system (the family) must attempt to restore equilibrium. Intervention programs can have an effect through either system.

Acceptance of the foregoing principles leads to some specific features that should be incorporated in the design of longitudinal research concerning the effects and costs of alternative types of early intervention for children with disabilities. First, interventions being evaluated should have child, family, and community emphasis. Second, outcome measures should be selected which measure both child and family functioning. Third, there should be examination of the interactional effects of mediating variables such as family socioeconomic status with intervention effectiveness. Finally, it should be just as important to determine the differential effects of alternative types of intervention, as it is to evaluate the overall effects of intervention.

FOCUS OF THE LONGITUDINAL STUDIES

Sixteen longitudinal research studies were implemented to address the issues outlined by the U.S. Department of Education in the original RFP. These studies can be grouped into three categories, as described below.

Effects of Varying the Intensity of Intervention

The first series of studies addressed the issue of treatment intensity. For each study in this group, an existing high-quality early intervention program was identified and a more intensive alternative was developed.[1] Children were randomly assigned to the existing program or to the more intense alternative, and outcomes were assessed. For example, in the SMA study, a group of children with moderate to severe disabilities were identified in a program in Illinois which was providing one day per week of center-based services. Using money from a grant funded by the state of Illinois, half of the children were randomly assigned to receive the same type of services three times per week. A total of seven studies initially investigated the intensity issue, four of these were continued as part of the Follow-up Institute.

Effects of Beginning Intervention at Different Ages

Another very important issue with respect to early intervention is the determination of the most appropriate age at which services should begin. In another set of studies, groups of underserved children with disabilities were identified. A comprehensive intervention program was developed, and children were assigned to begin participation in the intervention program either immediately or at some time in the future. For example, prior to the initiation of this research, infants who had suffered an intraventricular hemorrhage (IVH) were provided with medical follow-up but no systematic early intervention services when they were released from the Neonatal Intensive Care Unit (NICU) at the University Hospital in Salt Lake City. With the initiation of this research, such infants were randomly assigned to one of two groups. Children in the first group received a home-based early intervention program immediately after being released from the NICU; children in the second group began receiving similar early intervention services when they were 18 months old. Four of the 16 studies initially investigated this issue and two were continued in the Follow-up institute. Both of the studies use severely medically fragile children as subjects.

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[1] It is recognized that "intensity" can vary along many different dimensions, including frequency of service, engaged learning time, adult/child ratios, availability of therapy services, etc. Each study in this group addressed some, but obviously not all of those issues. For a more complete discussion of these issues, and a review of the literature related to the effects of varying early intervention intensity, see Innocenti and White (1993).

Effects of Variation in Program Components

Several studies compared experimental conditions in which services were provided to children with disabilities in systematically different ways. For example, the Des Moines Public Schools was already providing classroom-based early intervention services for children with disabilities. However, the involvement of families in that program was limited to IEP meetings, Parent/Teacher conferences, and fairly routine communication about the program's activities. Working in conjunction with EIRI, Des Moines developed a comprehensive family involvement program which was systematically added to the classroom-based program. This component included providing families with an effective support network through other families and professionals and assistance in accessing existing social service programs, in addition to training family members to provide brief structured daily therapy specifically focused on the child's developmental needs.

Children being served by the program were assigned to one of two groups, both of which continued with the classroom-based program. One group continued the previous minimal family involvement, while the comprehensive family involvement component was added to the other. A total of five studies initially investigated program variation questions. Three of these studies were continued in the Follow-up Institute.

RESEARCH SITE SELECTION

In selecting the original 16 research sites, over 70 potential sites were contacted. The rationale and objectives for the longitudinal research was described, and the degree to which each site met the following criteria for inclusion was assessed.

(a) ability to randomly assign subjects,

(b) sufficient differences between the two alternative treatments,

(c) sufficient number of children,

(d) willingness to provide cost information,

(e) ability to participate in child assessments on a longitudinal basis,

(f) staff interest in the project, and

(g) ability to fund any expanded services that were necessary for the comparison.

Onsite visits were made to those sites which seemed most promising, and 16 sites were eventually selected for participation in the longitudinal studies. More detailed descriptions of the procedures for selecting the final sites are given by White (1986).

During the fourth year of the initial contract, a site visit was made by representatives of the U.S. Department of Education. During the site visit, all research activities were reviewed. As a result of the site review, the site visitors recommended that 9 of the original 16 studies be considered for continued funding. This recommendation was discussed with the institute's Advisory Board.

The end result of this process was that the Department of Education issued the competitive RFP for the continuation studies. This contract, awarded to Utah State University, stipulated the schedule of assessment and required certain types of assessment be conducted.

COMMON STUDY ELEMENTS

Even though the studies were conducted in geographically diverse sites, with children differing in disability type and with different research comparisons, common study elements described below were included in each study to enhance the scientific control and to allow for cross-site comparisons.

Random Assignment to Groups

Although many early childhood researchers have questioned the feasibility and ethics of randomized experiments in early intervention research, it became clear during the planning year that random assignment could be done feasibly and ethically in this particular set of studies as long as certain procedures were followed (see White & Pezzino, 1986, for a more complete discussion of these issues). Each of the studies compared two alternative forms of early intervention by randomly assigning children who met pre-specified criteria to one of the two groups. In each study, parents' informed consent to participate in the study was obtained prior to random assignment. Random assignment was done by researchers at EIRI so that:

- ☐ Each child had an equal chance of being assigned to any of the groups within that study.
- ☐ Service providers or parents could not influence the decision about the group to which a particular child was assigned.

In each study, stratification techniques were used prior to randomization to increase the statistical power of the design and to reduce the probability of random fluctuation resulting in large pretreatment differences between the groups on the variables most relevant to the outcomes being measured. More detailed explanation of the stratification procedures used and the procedures for random assignment are described in White (1987).

It is important to note that randomized comparative studies of early intervention are much more prevalent than is often assumed. Many of the most widely cited studies in the field (e.g., the Perry Preschool Study [Weikart, Bond, & McNeill, 1978], the Abecedarian Project [Ramey et al., 1976], and the Infant Health and Development Project [1990]) used randomized designs. The longitudinal studies reported in this issue had very little difficulty implementing randomized designs.

Impartial Data Collection

It is well documented in the social sciences that people tend to see what they expect to see (e.g., Foster, Ysseldyke, & Reese, 1975; Rosenthal, 1976). A major problem with past early intervention efficacy research has been the tendency to use data collectors who not only knew which children were receiving the experimental treatment, but also had a vested interest in the outcome. In the meta-analysis of early intervention research reported by White and Casto (1985), only 21% of the effect sizes came from studies utilizing "blind" data collectors. The failure to use impartial data collectors is a major design flaw, especially in light of a substantial body of research (e.g., Gould, 1983), which suggests that expectations, even when they are subconscious, can be a powerful influence on how data are collected and interpreted.

All of the studies conducted by this project used data collectors who were unaware of the purpose of the experiment and the group membership of the subjects. This relatively simple procedure eliminated an important threat to the studies' internal validity. Another strategy to ensure high-quality data collection was to develop a rigorous training program for the diagnosticians who administered the tests, certify them if they qualified after training, and shadow score and videotape a sample of the administrations to ensure measures were being administered in a standardized fashion.

Assessing the Impact of Early Intervention on Broad Measures of Child and Family Functioning

Some of the most difficult issues to satisfactorily resolve in conducting longitudinal research on the effects and costs of early intervention with children with disabilities are the questions surrounding instrumentation: What data to collect? When to collect those data? How to ensure that data are collected satisfactorily? Regarding instrumentation for early childhood special education research, the one thing which is abundantly clear is that the procedures for assessing child change attributable to intervention are inadequately developed, and totally satisfactory instruments are not available. With regard to measuring the impact of early intervention on families, the field is even less well developed.

Over the past decade, there has been a growing awareness that efforts to evaluate the efficacy of early intervention programs have often been too narrowly focused (Casto & Lewis, 1984; Ramey et al., 1982; Simeonsson et al., 1982; Zigler & Balla, 1982). Past early intervention efficacy research has focused on easily available, psychometrically sound measures of intelligence, and has largely ignored other areas of child functioning such as social-emotional growth and adaptive behavior, as well as indicators of family functioning.

Because resources for evaluation are always limited, it was impossible to collect all of the data that might have been of interest. However, it was crucial to pay more attention to areas such as social-emotional growth and family functioning. The studies conducted as part of this project selected measures based on two sources of information: (a) what would be predicted by the theoretical/ conceptual framework underlying the longitudinal studies and the particular intervention program, and (b) which areas have other investigators identified as important with similar types of interventions.

Information such as cognitive, motor, and language functioning were, of course, collected. However, additional information such as mother and child interaction, parental attitudes toward their child with a disability, child success in school as indicated by special education class placement and grade retention, and perceived stress as reported by the parents was also collected. In each case, the specific goals and activities of the intervention program was the primary consideration in selecting assessment instruments. The final assessment battery included a series of core instruments which were administered at all sites and a series of complementary measures which were site specific. The core measures used at all sites are:

Child Measures

Battelle Developmental Inventory (BDI) (Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984)
Woodcock-Johnson Tests of Achievement (WJ-R) (Woodcock & Johnson, 1989)
Scales of Independent Behavior (SIB) (Bruininks, Woodcock, Weatherman, & Hill, 1985)
Social Skills Rating Scale (SSRS) (Gresham & Elliott, 1990)
Pictorial Scale of Perceived Competence and Acceptance (Harter & Pikes, 1983)

Family Measures

Parenting Stress Index (PSI) (Abidin, 1983)
Family Support Scale (FSS) (Dunst, Jenkins, & Trivette, 1984)
Family Resource Scale (FRS) (Dunst & Leet, 1985)
Family Inventory of Life Events and Changes (FILE) (McCubbin, Patterson, & Wilson, 1983)
Family Adaptation and Cohesion Evaluation Scale-III (FACES) (Olson, Portner, & Lavee, 1985
Child Health (White et al., 1987).
Additional Services (White et al., 1987)
Family Information Survey (White et al., 1987)

A detailed explanation of these measures, as well as the site-specific measures, are included in each individual site report. A more detailed explanation of the rationale for selecting these particular measures and the psychometric properties of each measure are given by White (1986).

Treatment Verification

Most reports of the past early intervention efficacy research have failed to explain whether procedures were used to determine the extent to which the intended treatment was actually implemented and how it was experienced by participants. For example, for programs which intended to use parents as intervenors in their child's program, very few report whether parents became involved to the degree intended by the program designer, whether they understood what was expected of them, or whether they carried out the intervention consistently and appropriately. Unless such information is obtained, there is a real danger that comparisons will be made between programs that were intended to be different but that, in fact, were not. The importance of using treatment verification procedures was pointed out by Casto and Lewis (1984), who noted that the failure to verify whether intended treatments were actually implemented may be partly responsible for the lack of significant findings in those early intervention studies which compared high and low levels of parental involvement.

To address the problems of interpretation and the resulting ambiguities when there is little or no evidence regarding the fidelity of treatment procedures, each of the longitudinal studies used both self-evaluation procedures and external monitoring to document the degree to which intended treatments were actually implemented. These procedures were tailored to the individual studies but generally involved site visits by staff members external to that particular project who used checklists, questionnaires, and rating forms to document the delivery of services. Additional information was collected using attendance data, teacher logs, parent questionnaires, and telephone monitoring. The cost data collected at each site are based on detailed descriptions of the interventions.

Treatment verifications procedures served four purposes in the longitudinal research:

(a) The data allowed for an independent and empirical confirmation that alternative interventions were implemented as intended. Where departures from the original plan occurred, information was provided on which appropriate technical assistance could be based;

(b) The nature of data collection for the treatment verification process served as a stimulus for self-improvement and consistent implementation;

(c) A comprehensive description of research conditions allowed better understanding and generalizability of results; and

(d) Data were used to document which subjects participated more extensively so that this could be accounted for in the data analysis.

In the treatment verification procedures for the longitudinal studies, multiple data sources were used to cross validate treatment implementation data sources.

These triangulation procedures (Denzin, 1978; Mercer, 1979) required that data from one source be verified or confirmed by data from other sources. In the case of treatment implementation, self-report data collected from intervention personnel were compared to data collected through direct observation and records.

Technical Assistance

Early intervention efficacy research is sometimes criticized on the grounds that research studies are often conducted in university laboratory schools with such high levels of funding that the results are unlikely to be replicated in more typical service delivery settings. A second and even more serious criticism could be offered if research were conducted with programs of such poor quality that they might fail to produce the effects which would have occurred if a better intervention program had been implemented.

To prevent these problems, all of the longitudinal studies were conducted in conjunction with ongoing service programs willing to expand or vary the services they were providing in a systematic manner which still reflected the "state-of-the-art" practice in the field. Each site was visited frequently by EIRI staff and/or independent onsite evaluators to verify the type and quality of intervention being provided. Where necessary, technical assistance or inservice training was provided.

Economic Evaluation

A major shortcoming of past early intervention efficacy research has been the failure to consider simultaneously both the effects and costs of intervention. The fact that most studies have ignored costs altogether suggests a tacit assumption that unlimited resources are available for such programs. This is obviously incorrect.

As an example of why both costs and effects need to be considered simultaneously, consider three hypothetical programs which are all designed to reduce the incidence of later special class placement for preschool children who are developmentally delayed. Data from this hypothetical study are shown in Table 1. Program A is the most effective, since 17 of the 20 children are placed in regular programs at first grade, but the cost is $20,000 per participant. Program B is the cheapest at $500 per participant, but only 2 of the 20 children are placed in regular classrooms. In Program C, 14 of 20 children are placed in regular classrooms at a cost of $2,000 per participant. If an administrator wanted to pay as little as possible for the program, B might be selected. Unfortunately, little benefit would be realized. In a society with unlimited resources for such programs, Program A would probably be the method of choice because it is the most effective. However, in a more realistic situation where resources are limited, Program C would probably be preferred. Although rates of placement in regular classrooms are somewhat lower for Program C, the cost of the program is a fraction of the cost of Program A. Thus, neither the most effective nor the cheapest program is the most cost-effective alternative.

Table 1

Example of a Hypothetical Cost-Effectiveness Matrix for Evaluating Alternative Early Intervention Programs

Program	Cost Per Child	N	Placement in Regular Education
A	20,000	20	17
B	500	20	2
C	2,000	20	14

Accounting for the costs of a particular early intervention program is more complex than taking the budget for that program and dividing it by the number of children served. Instead, as was done in each of the longitudinal studies, it is crucial to account for shared and contributed costs, as well as to use standard economic techniques for calculating difficult-to-estimate costs, discounting, judging the robustness of economic assumptions, and figuring benefits. Economic evaluation of social service programs is a relatively new field but one which is becoming increasingly important as people realize that we do not have unlimited resources for providing such services.

CONSISTENCY WITH CONTEMPORARY INTERVENTION APPROACHES

An issue that can be raised regarding the studies presented in this report is their consistency with contemporary intervention approaches. The studies reported herein were begun from five to nine years ago, and early intervention activities have been expanding over that time period as a result of the implementation of IDEA. Issues regarding whether these studies represent current best practice can be raised. Unfortunately, much of what people claim to know about best practices consists of opinions that happen to be in vogue, but for which there is little, if any, empirical documentation (Peters & Heron, 1993).

The more pertinent issue for the studies reported here is the relationship of best practice concerns to the results of rigorous experimental research. Numerous recent articles and books refer to "best practice" guidelines (see for example, Council for Exceptional Children, CEC, 1993; DeStefano, Howe, Horn, & Smith, 1991; Hanson & Lynch, 1989; and McDonnell & Hardman, 1988), but what is "best practice" when it comes to early intervention? Clearly, the answer depends on the nature of the children enrolled in the program and the outcomes desired. For example, a "best practice" early intervention program for two-year-old children who are deaf/blind will be different than a program for five-year-old children with speech delays. At a general level, however, it seems reasonable that one could identify some "best practice" characteristics that are usually applicable to early intervention programs serving children with disabilities and their families.

Supporting this view, an analysis of the recent "best practices" literature, reveals a fair amount of consistency. A summary of the information presented by several different recent articles (CEC, 1993; DeStefano et al., 1991; Hanson &

Lynch, 1989; and McDonnell & Hardman, 1988) reveals substantial agreement about the following areas of best practice:

1) Individualized programs in which the needs of children and their families are individually assessed and individually tailored and flexible programming is developed based on those assessments.

2) Integrated services which provided appropriate support and systematic contact with peers who are not disabled.

3) Family-focused programs which treat the family as a unit, include parents as full partners in planning and decisions, and empower and support parents in their roles rather than having professionals attempt to assume those roles.

4) Developmentally appropriate and functional activities which focus on enhancing the child's skills within the normal family routine, and emphasizes the function rather than the form of response.

5) Transdisciplinary staffing which allows coordinated input from multiple perspectives, coordinates interagency activities, and assists the family in efficiently dealing with medical, educational, and social service needs.

6) Outcome-based focus of intervention which provides the foundation for efficient and successful transition to future integrated settings.

7) Comprehensive assessment, planning, programming, service coordination, and evaluation which strives to address all of the child's developmentally relevant needs.

8) Normalized practices which provide age-appropriate instructional strategies, opportunities for generalization across settings, self-initiated responding, and avoids artificial reinforcement and aversive control techniques.

9) Multicultural compatibility so that intervention activities are appropriate for families who hold values or identify themselves as members of ethnic groups that differ from the mainstream in American society.

Although sensible, there are two problems in using the guidelines outlined above for deciding how to design appropriate early intervention programs. First, most of these guidelines are not based on convincing empirical data. Instead, as pointed out by the authors of the Division of Early Childhood Recommended Practices (CEC, 1993),

> ...some indicators are firmly held as recommended practice, but a program of research has not been conducted to demonstrate their positive effects. That is, they reflect the values of our field and may precede empirical validation. In such cases, indicators would be value-driven and supported by a consensus within the field. (p. 4)

The second problem is that the best practices outlined above are so general that many of the decisions that must be made in designing an early intervention program remain unaddressed. For example, assume that the program administrators responsible for designing a community-based early intervention program for three-year-old children with moderate-to-severe developmental delays followed all of the preceding guidelines. The administrator would still have to make decisions about dozens of other variables (e.g., whether the program should be home-based or center-based; how many hours per week services should be provided, what type of training and certification the interventionists should have, etc.). In all the possible combinations of these variables one could still adhere to all of the "best practices" guidelines summarized above, but completely different programs with substantially different costs, and perhaps very different outcomes would result. Thus, assuring that a program is adhering to guidelines for "best practices" does not answer some of the critically important questions related to designing the most cost efficient early intervention programs.

Even if we agree that all of the studies in this report were not best practice, they were and are consistent with what would be considered appropriate practice. Roberts and Wasik (1990) reported that the median frequency of home-based visiting across the United States is once per week. Shonkoff, Hauser-Cram, Krauss, and Upshur (1992) report a median of three hours of home visiting per month in their study. The SMA study examines the results of increasing the frequency of home visiting from once per week to three times per week.

Parent involvement group meetings continue to be a common form of parent involvement (Mahoney & O'Sullivan, 1990; Shonkoff et al., 1992). The parent involvement group comparisons reported here are as, or more intensive than, what these studies report.

The age-at-start interventions used with the medically fragile infants are similar to other reports in the literature. A study reported by Rauh, Achenbach, Nurcombe, Howell, and Teti (1988) provided an additional 11 hours of intervention focused on mother's adaptation for infants biologically at-risk without medical impairments, in addition to the ongoing substrata of early intervention. The Salt Lake City Medically Fragile Study, in contrast, provides an additional 17 hours of a sensorimotor stimulation intervention for biologically at-risk children with medical complications, on top of the existing substrate of early intervention. The Columbus study examines the impact of a case-management team on services for medically fragile infants and demonstrates significant increases in services received.

The interventions used in the studies in this report are the kinds of interventions that are being pushed with greater vigor across the United States as a result of the implementation of IDEA. Classroom-based programs that do not have strong parent components are seeking ways to increase their parent involvement, and many are turning to strategies similar to those reported here (Mahoney & O'Sullivan, 1990). Whether to provide home intervention once per week or three times per week, how often should children attend classroom-based programs, or how to supplement medical follow-along programs (see IHDP, 1990) are exactly the kinds of questions that program administrators have to answer.

Given this information, we are confident stating that the intervention approaches reported here are consistent with current intervention approaches being practiced. The use of multiple measures of child and family outcomes are consistent with current theoretical approaches to intervention. The collection of treatment verification data and the use of these data to help explain potential mediator influences on intervention is also consistent with system theory. The rigorous procedures used to conduct these studies represent quality research as currently discussed in the early intervention literature (Guralnick, 1993). However, the information gained from these studies is more appropriate to influence future research rather than have an immediate impact on policy decisions.

Knowledge about what type of early intervention is best for which children under which conditions is a gradual cumulative process that requires hundreds of studies by dozens of different researchers over a substantial period of time. The information yielded by the studies reported herein provides important data about some of the most important questions facing the field of early intervention (e.g., intensity of intervention, age at start, and parent involvement). However, these studies do not provide final definitive answers to these issues, nor is it really possible for any one study to do that. Even a simple question such as, "Are more intensive early intervention programs more cost-effective than less intensive ones?" is an extremely complex, multi-faceted question which cannot be resolved fully with a dozen well-designed studies. For example, in discussing more intensive interventions, what issues are most important: the frequency with which intervention is delivered, the percent of time children are actively engaged in learning activities, the adult:child ratio by which intervention is delivered, or the availability of support services to both the child and the family? Does the issue of intensity interact with other variables such as the type and severity of the disability? Is it possible that more intensive interventions may be more effective for some outcomes but actually damaging for other outcomes? As these questions demonstrate, the question which at first sounds so simple, "Are more intensive interventions more effective?" is really a very complex series of questions, each of which needs to be addressed with several different research studies conducted by independent people so that a convincing body of evidence can be amassed. The studies described in this report are an example of the kinds of studies that need to be conducted. However, by themselves, they do not provide definitive answers to any of the questions posed regarding the effectiveness of early intervention. Instead, they are a piece of a mosaic that when put together with other pieces will provide much better information on which practitioners and administrators can base decisions about what kind of intervention services to provide. Unless the type of research exemplified by these studies is continued, then service providers will have no alternative but to make those decisions based on the amount of money available to provide services, their own opinion about what constitutes the most effective service, or which advocacy group is most persuasive.

CURRENT ACTIVITIES

During the 1993-94 year, individual site coordinators continued to make periodic site visits and regular telephone contacts with each of the sites. Site coordinators supervised the collection of contextual data that may impact outcomes, and school placement information outcome data, at each of the sites. Because of turnover in diagnosticians, it was necessary to continue to train a few diagnosticians. Monitoring procedures were continued to ensure high-quality assessments. The early intervention programs in most sites were no longer operational for children participating in the research since these children had "graduated" into public school programs. Arrangements were made to continue to follow those children and collect data annually. As outcome data were collected, site coordinators were responsible for cleaning, double checking, and entering the data into the computer for subsequent analyses.

The important task of minimizing attrition among participating child and families continued as a major responsibility of site coordinators. Children who had completed early intervention programs and moved to other parts of the country were located whenever possible and tested at appropriate times. In other cases, children had moved within the same geographic area and had to be relocated before testing could be done. In most sites, the efforts to relocate children have been successful, and the reassessment data included in this report often includes more children than the reassessment data from the 1988-89 year. The importance of having liaison people located at each of the sites has been emphasized in this process.

The training of graduate students and their involvement in the **Longitudinal Studies** continued as an important part of the contractual workscope for the project. During 1993-94, 13 different graduate students from special education, family and human development, sociology, and psychology were actively involved in the workscope of the **Longitudinal Studies**. Their responsibilities included supervision of data collection and coding, telephone interviews with parents, data analysis and interpretation, and report writing.

In addition to these students who were employed an average of 20 hours per week, many additional graduate students from Utah State University and other universities were trained and certified to do educational assessments as a part of the **Longitudinal Studies'** workscope. These students were paid according to the number of assessments they completed. Other graduate students were also involved in the **Longitudinal Studies** in the use of data for research projects for degree requirements. Finally, a number of undergraduate students participated on the **Longitudinal Studies** as clerks for research sites, as work-study students, or on undergraduate research experiences.

The activities of the staff regarding dissemination of project results also increased. As more data has been collected, the results of these studies have been presented at national meetings and submitted to journals for publication.

SUMMARY OF RESEARCH STUDIES

The bulk of this report contains individual reports for each of the nine studies included in this project. Before presenting those detailed reports, a summary of the design and results of each study is presented. The following pages describe the most critical information about the design of each study and graphically summarizes the results for child and family outcomes. These tabular and graphical representatives are best interpreted in conjunction with the remainder of the final report from the Early Intervention Research Institute and should not be viewed as an adequate substitute for that report.

Two pieces of information are presented for each study. The first contains information about the alternative forms of intervention which were being examined.

The second page contains a graphic summary of the outcomes for the various measures of child and family functioning. This graph is interpreted as follows (see Figure 1). Outcome measures are listed down the left side of the page. Each graph has a vertical line down the center of the remainder of the page. Numbers opposite each outcome measure indicate whether it is the first reassessment (represented by "1"), second reassessment (represented by "2"), etc. The location of the number with respect to the vertical line indicates the results for that test. If the number is to the left of the line, the group on the left side of the line did better. The distance from the vertical line represents the size of the effect in standard deviation units. If a number has an asterix by it, the result was statistically significant at $p \leq .10$.

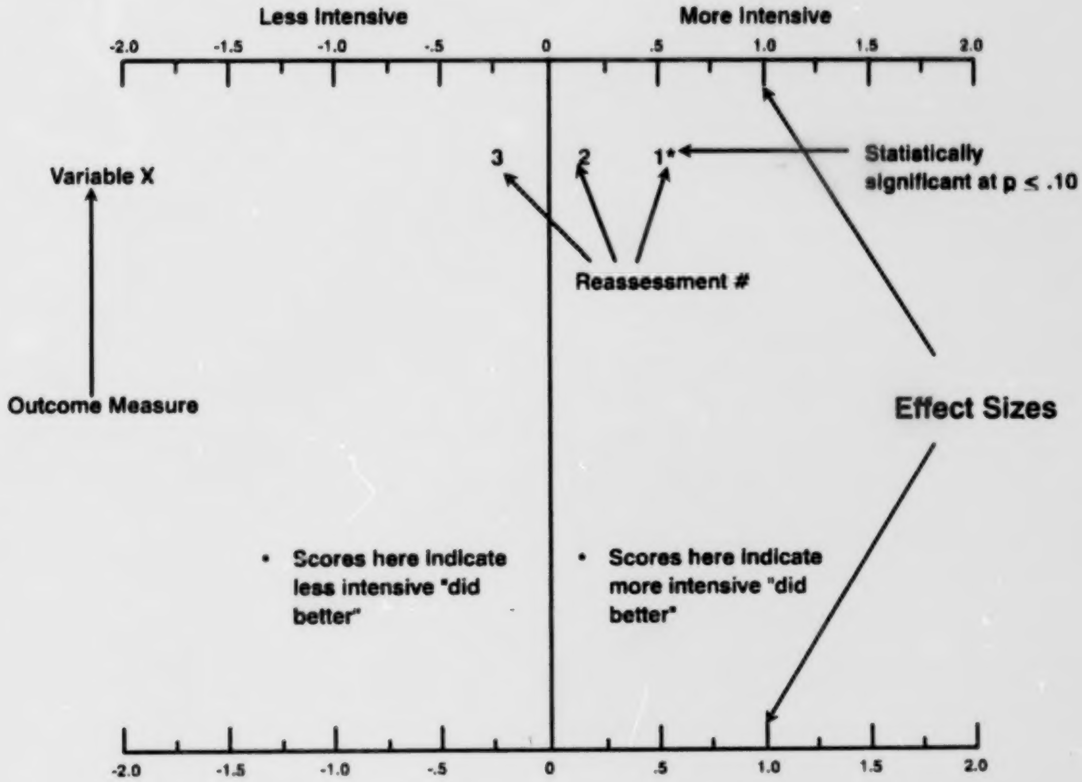
Less Intensive
More Intensive
-2.0
-1.5
-1.0
-.5
0
.5
1.0
1.5
2.0
3
2
1*
Statistically significant at p ≤ .10
Variable X
Reassessment #
Outcome Measure
Effect Sizes
• Scores here indicate less intensive "did better"
• Scores here indicate more intensive "did better"

Figure 1: Results Presentation Key

To illustrate for one study, consider the Jordan Intensity Study on pages 231 to 300. Two groups (3 days a week vs. 5 days a week) were compared on a variety of measures of child and family functioning. The result for the Battelle Developmental Inventory's cognitive subtest was about .27 standard deviation units in favor of the 5-day-per-week group at the first reassessment (statistically significant at $p \leq .10$) and .07 standard deviation units (not statistically significant) in favor of the 3-day-per-week group at reassessment #2. Larger bold numbers indicate the average effect for all child or all family measures for a particular posttest.

The interpretation of the results of each study depend on the **pattern** of results for the entire set of dependent variables as much as the individual results for various measures. This type of graphic representation provides a summary of the magnitude, direction, and statistical significance of a large number of measures which are useful in interpreting the overall effect of the alternative types of intervention.

NEW ORLEANS VISUAL IMPAIRMENT STUDY #1

Design

- 31 Infants/toddlers with mild-severe visual impairments randomly assigned to 2 interventions.

Low Intensity	High Intensity
• Contact with family average of 1 time per month	• Contact with family 4 times per month
• Contact with parent only	• Contact with parent and child
• General information related to VI given to parents	• Individualized Family Service Plan for child and family
• Parents seen in a small group	• Parents seen individually
• Meetings held at the center	• Most visits at the homes
• Variety of guest speakers	• Consistent primary intervenor (i.e., certified special education teacher and social worker)
	• Individualized consultation with O.T., P.T., speech/language therapist
• Group presentations by doctors, educators, therapists re: -- child development -- effects of visual impairment on development -- information regarding etiologies -- Reach Out and Teach Handbooks	• Intervention based on: -- Louisiana Curriculum -- Reach Out and Teach Handbooks -- Naturalistic teaching opportunities -- Focus on family and environment

Table 2
Effect Sizes for Child Outcomes for the New Orleans Visual Impairment Study

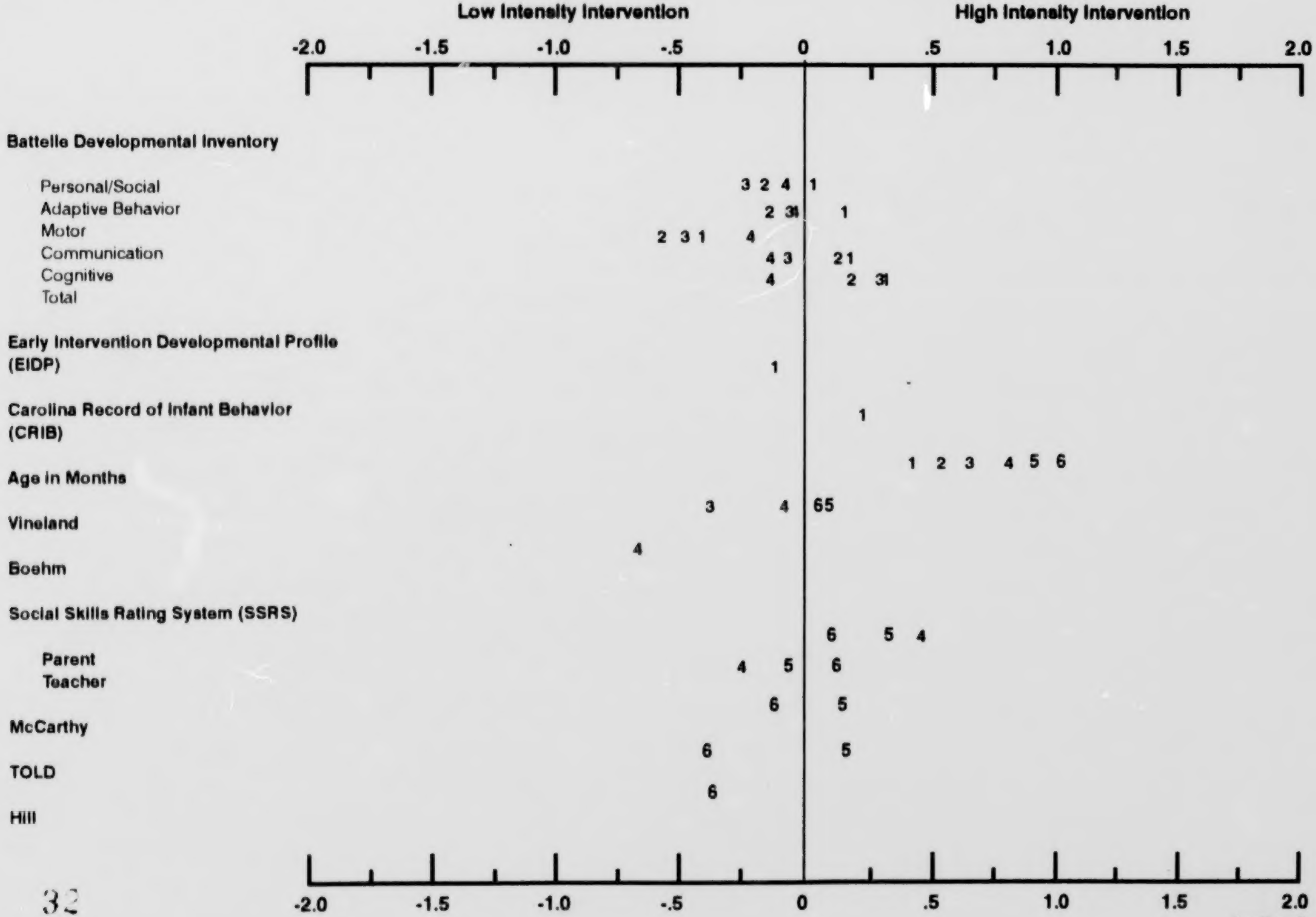

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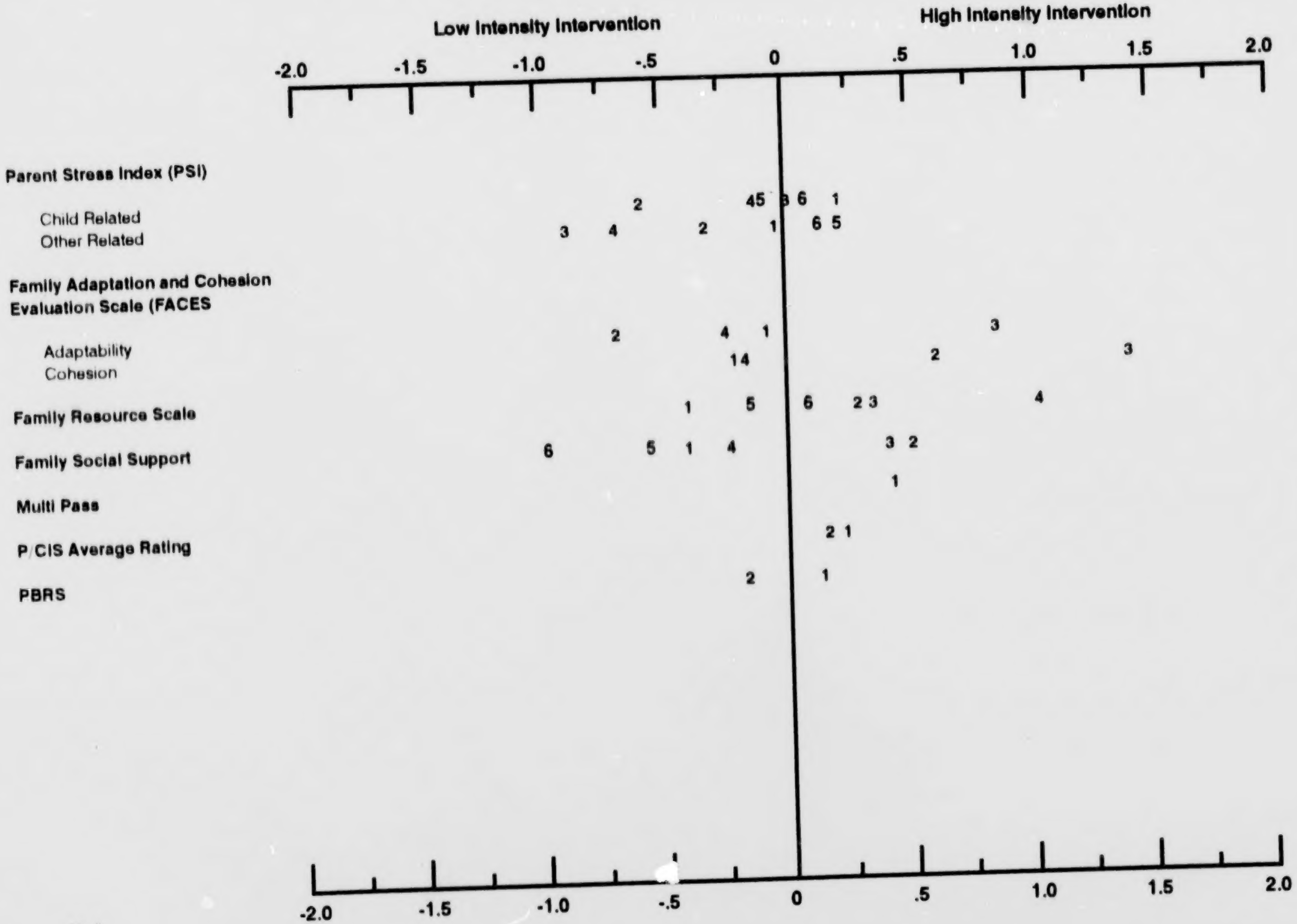
Table 3

Effect Sizes for Family Outcomes for the New Orleans Visual Impairment Study



SMA/LAKE MCHENRY INTENSITY STUDY #2

Design

- 72 children with disabilities randomly assigned to receive early intervention services 3 times per week versus 1 time per week.

- Services provided primarily at center by parent-infant educator. Some home services provided if transportation was a problem.

- Content of IEP driven by child assessment and family needs, but no specific curriculum used.

- Intervention focused on development in:

  -- personal/social
  -- adaptive behavior
  -- motor
  -- language
  -- cognitive

- Parents were expected to learn intervention techniques and implement them at home as appropriate. Program also provided emotional support to parents and assisted parents to obtain needed assistance outside the program.

Table 4
Effect Sizes for Child Outcomes for SMA Lake McHenry Study

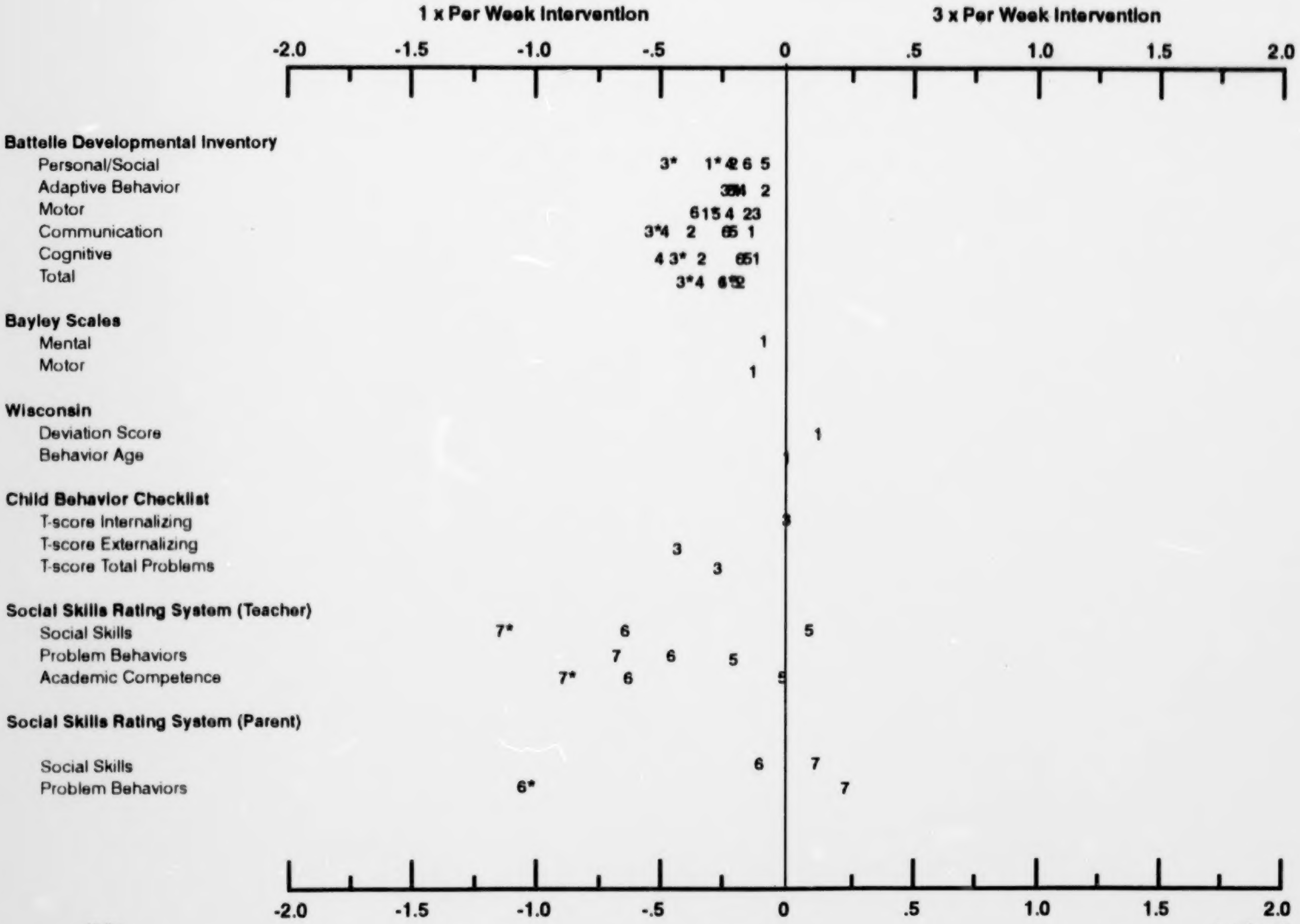


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Table 4 (continued)
Effect Sizes for Child Outcomes for SMA Lake McHenry Study

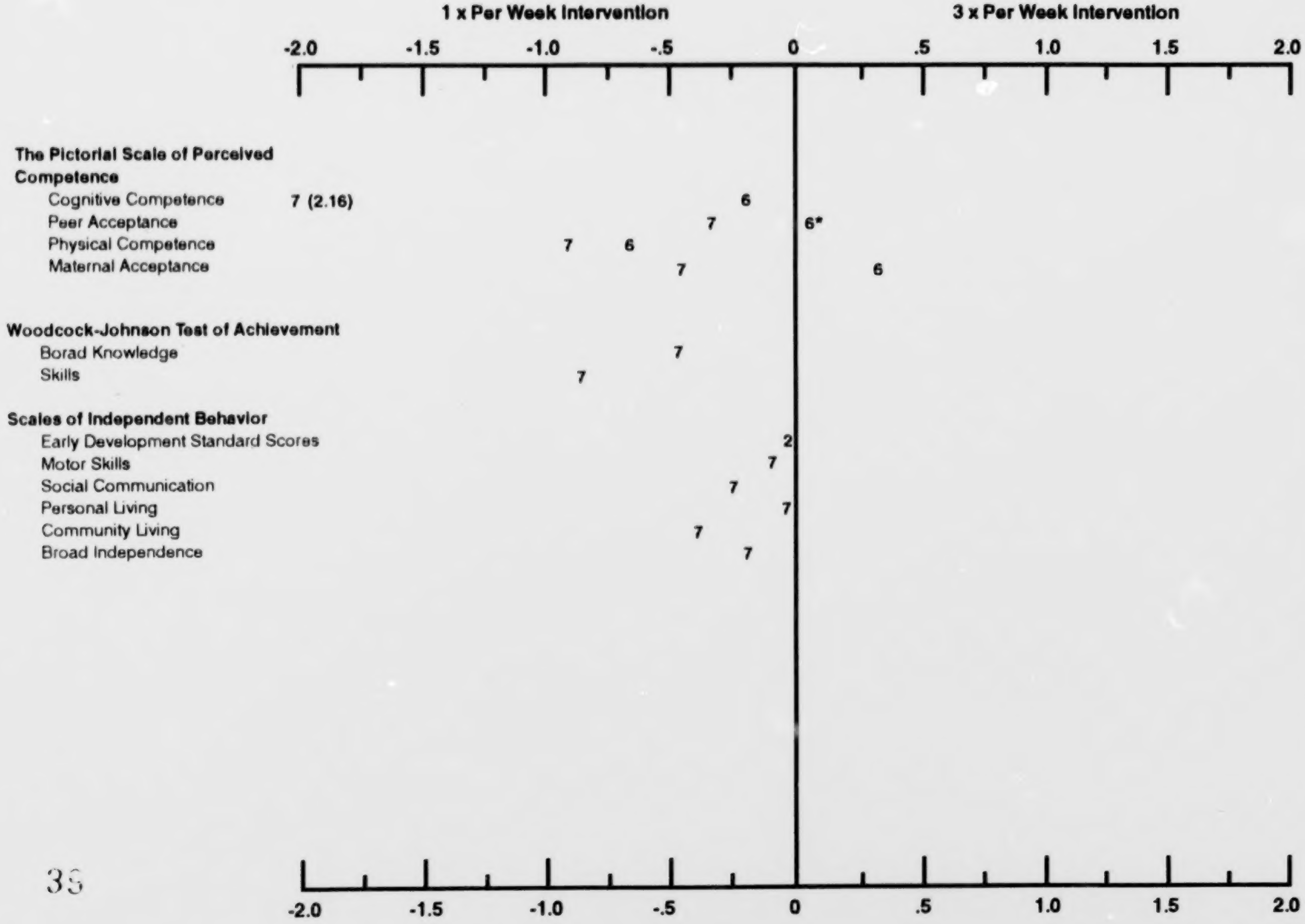
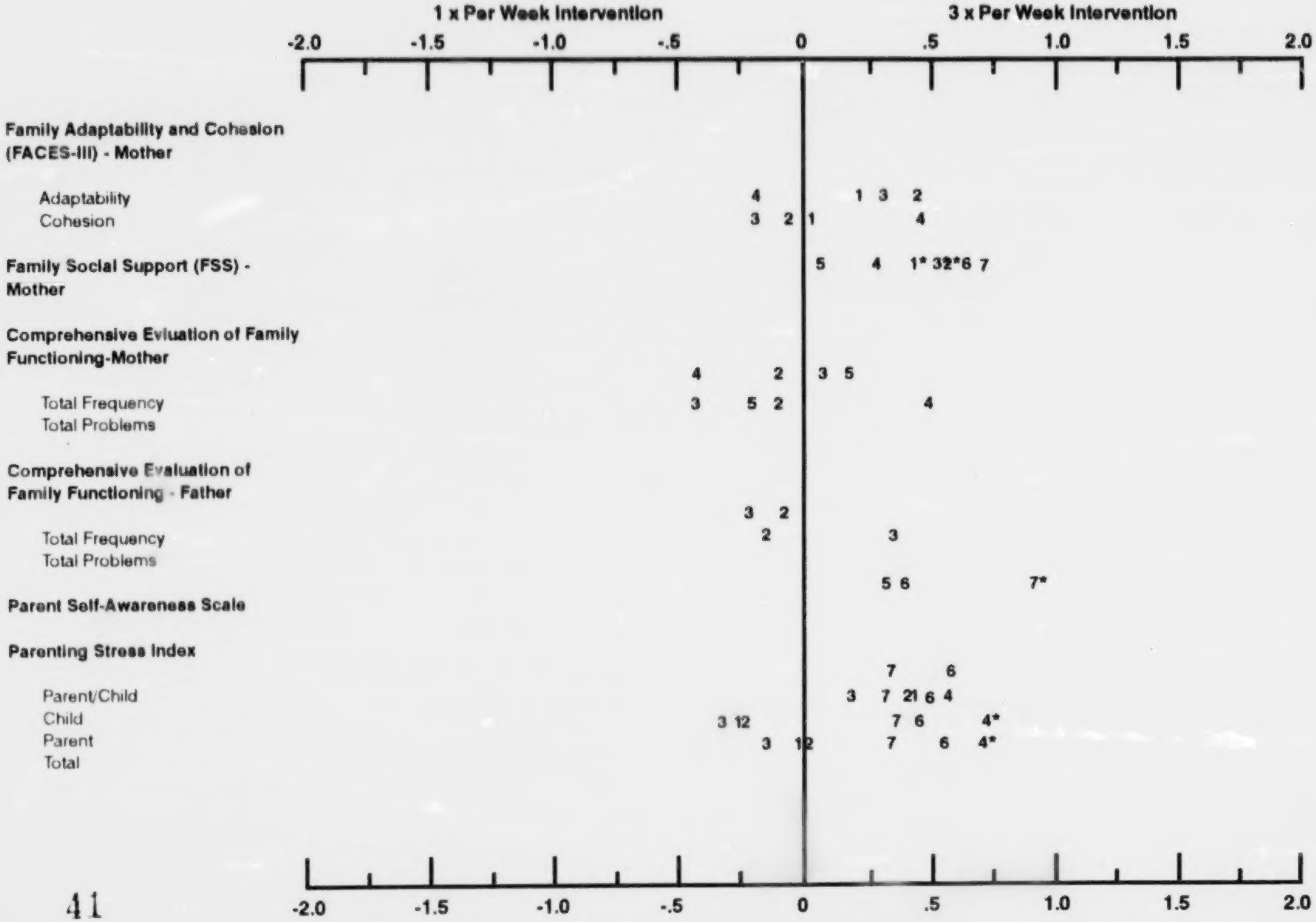


Table 5
Effect Sizes for Family Outcomes for SMA Lake McHenry Study



ARKANSAS INTENSITY STUDY #3

Design

- In two cohorts, 78 3- to 48-month-old children with disabilities randomly assigned to standard (1 time per week) or expanded (2 times per week) home-based interventions. Both cohorts were reassessed at 8, 18, 30, and 42 months following enrollment to intervention. Cohort 1 (n=58) has received additional reassessments at yearly intervals.

- Services provided by 9 trained paraprofessional home visitors, each of whom provided services to some children in each group.

- Intervenors worked directly with the child; parents expected to observe, to learn basic intervention techniques, to engage in follow-up activities, and keep data between visits.

- Intervention focused on development of functional skills in all developmental areas as specified by IEP. Most frequent areas of emphasis:

  -- self help (particularly feeding)
  -- gross motor
  -- communication

- Additional speech or motor therapy provided as needed in a center-based program.

Table 6
Effect Sizes for Child Outcomes for Arkansas Intensity Study

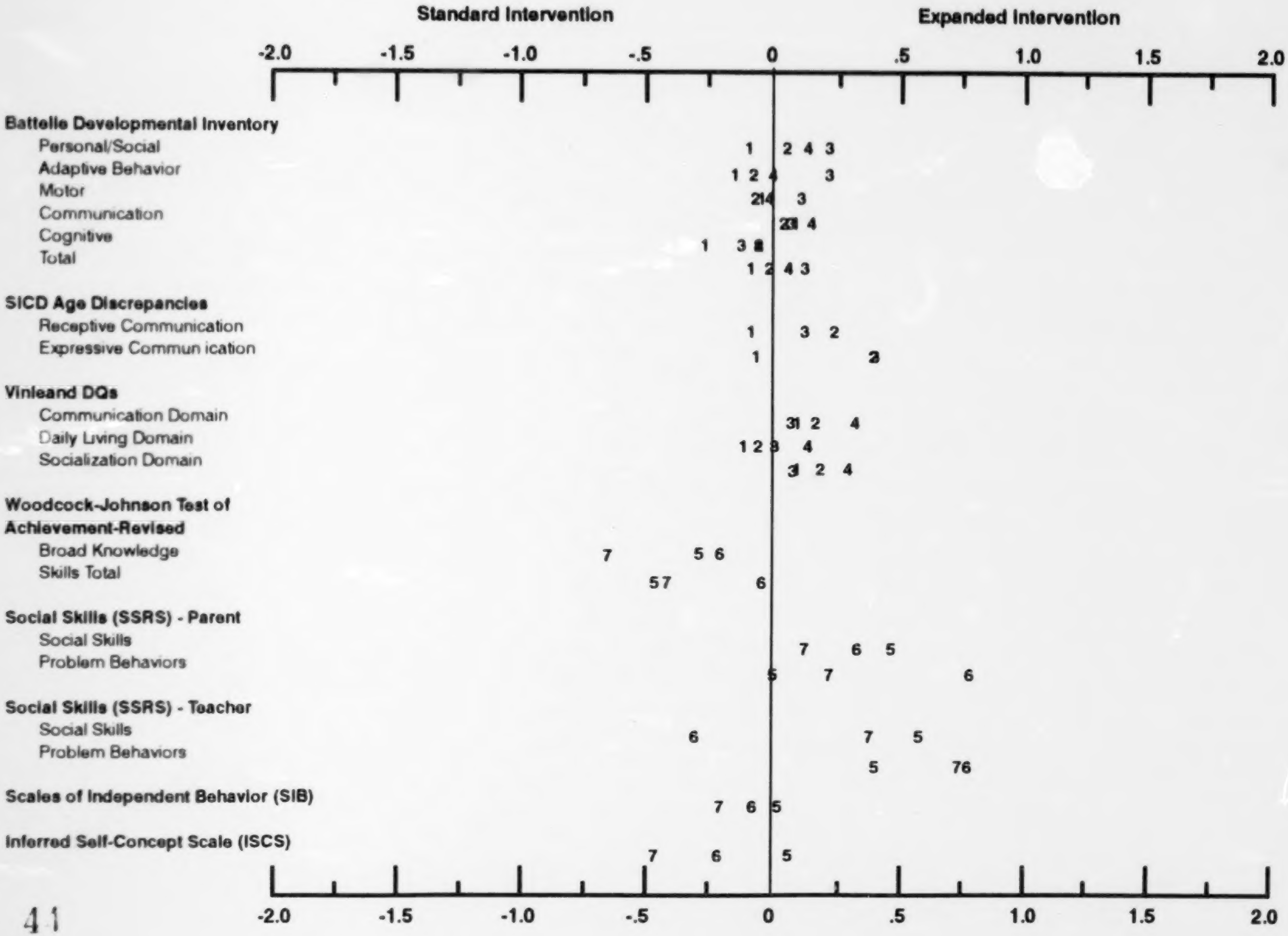
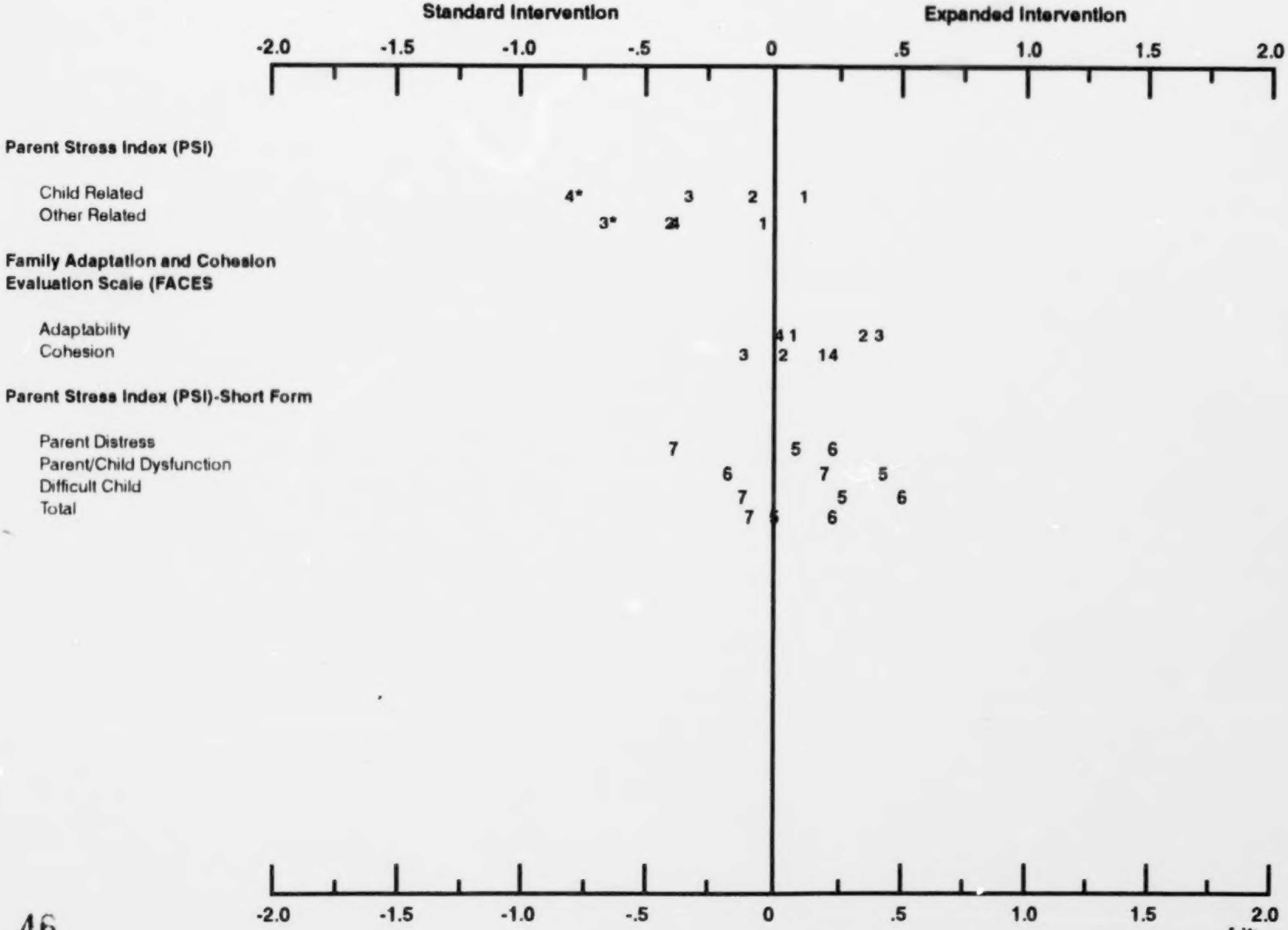


Table 7

Effect Sizes for Family Outcomes for the Arkansas Intensity Study



JORDAN INTENSITY STUDY #4

Design

- 53 preschool-aged children with severe to mild disabilities randomly assigned to two intervention groups.

Less Intensive Intervention Program	More Intensive Intervention Program
● 3 days per week; 2 hours per day	● 5 days per week; 2 hours per day
● 1:5 teacher/child ratio	● 1:3 teacher/child ratio
● One teacher assisted by two paraprofessional aides	● One teacher assisted by four paraprofessional aides
● Communication therapist available in classroom every other day	● Communication therapist available in classroom every day
● Intervention based on IEP using varied curricula through a theme-based, developmentally appropriate approach focused on teaching skills during daily activities	● Intervention based on IEP using varied curricula through a theme-based, developmentally appropriate approach focused on teaching skills during daily activities

Table 8
Effect Sizes for Child Outcomes for the Jordan Study

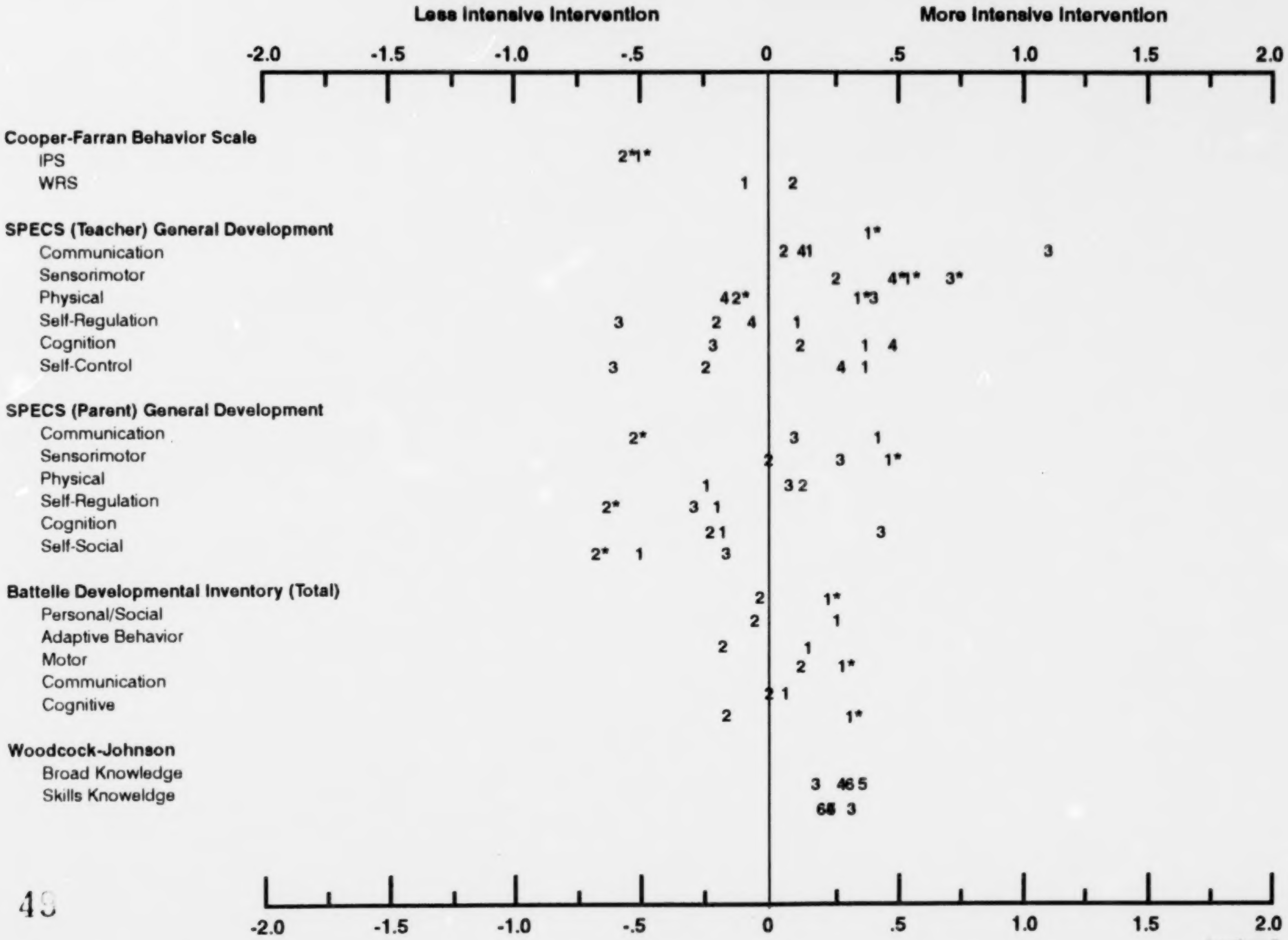


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Table 8 (continued)
Effect Sizes for Child Outcomes for the Jordan Study

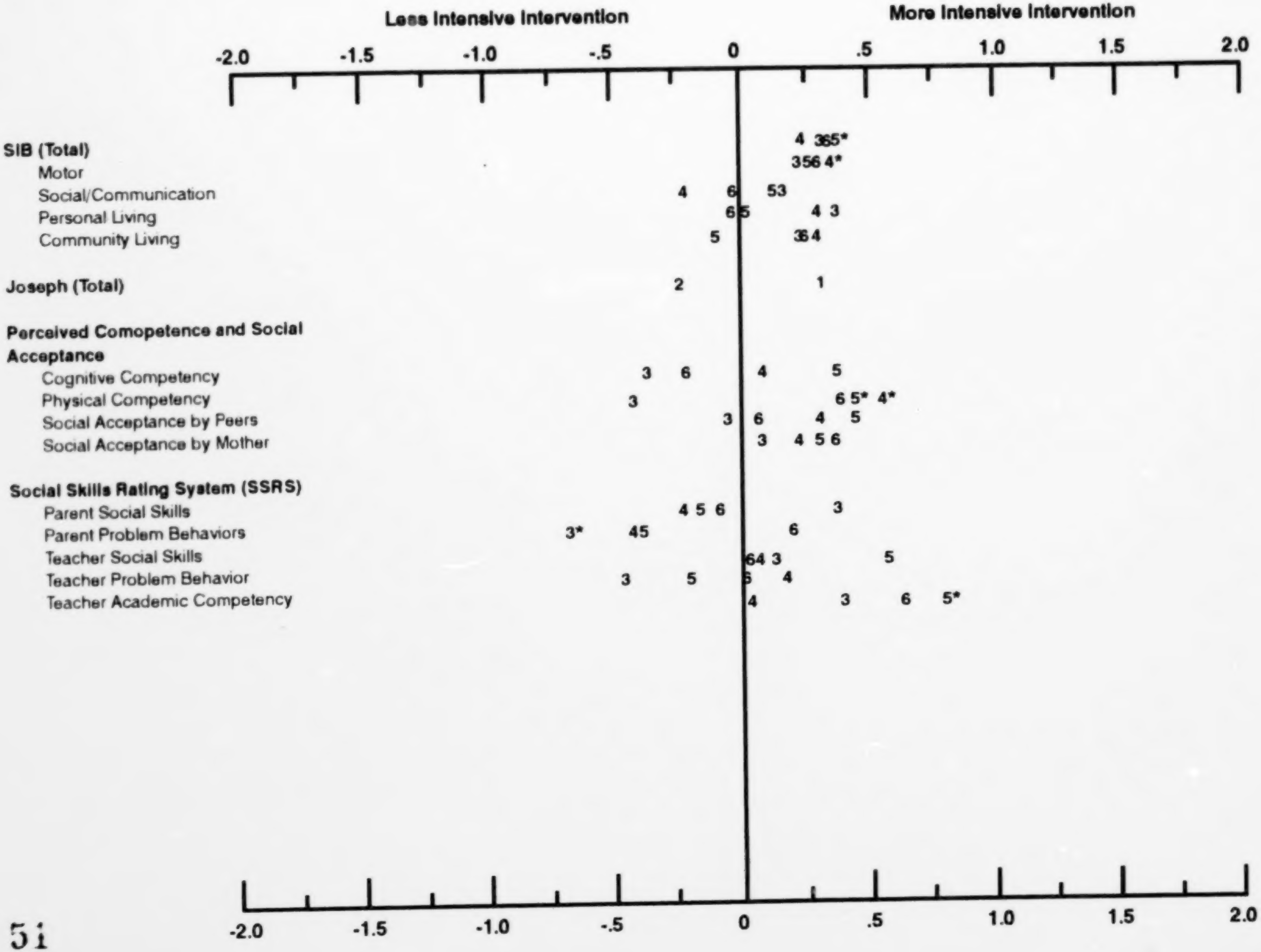
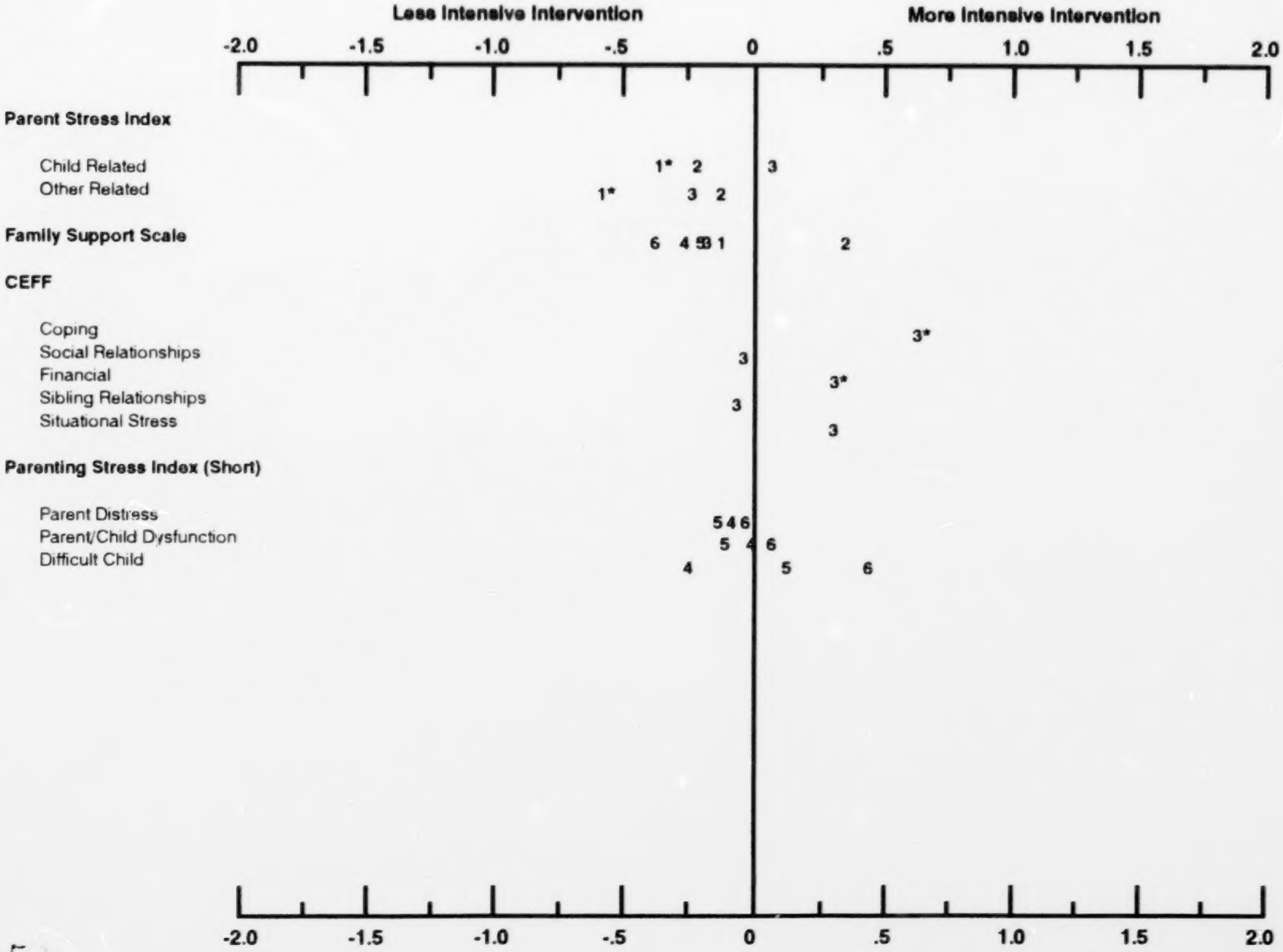


Table 9
Effect Sizes for Family Outcomes for the Jordan Study



SALT LAKE CITY MEDICALLY FRAGILE STUDY #5

Design

- 58 infants with intraventricular hemorrhage (IVH) randomly assigned to 2 intervention groups.

Delayed Intervention	Early Intervention
3 Months Corrected Age	**3 Months Corrected Age**
• Medical follow-up: Utah State Department of Health neonatal Follow-up Clinic or private physician	• Medical follow-up: Utah State Department of Health Neonatal Follow-up Clinic or private physician
	• Sensorimotor intervention -- Registered physical/occupational therapist -- Curriculum and Monitoring System (CAMS) Motor Program -- 1:1 child/therapist ratio -- Parent instruction -- Monthly to weekly visits -- Home-and/or center-based
	• Assistance in locating community services
18 Months Corrected Age	**18 Months Corrected Age**
• Sensorimotor intervention	• Sensorimotor intervention
• Developmental intervention	• Developmental intervention
• Certified teacher	• Certified teacher
• CAMS curriculum (emphasis on receptive and expressive language, social-emotional, and self-help skills)	• CAMS curriculum (emphasis on receptive and expressive language, social-emotional, and self-help skills)
• Parent instruction	• Parent instruction
• Monthly visits	• Monthly visits
• Home- and/or center-based	• Home- and/or center-based
• Assistance in locating community services	• Assistance in locating community services

Table 10
Effect Sizes for Child Outcomes for Salt Lake City Medically Fragile Study

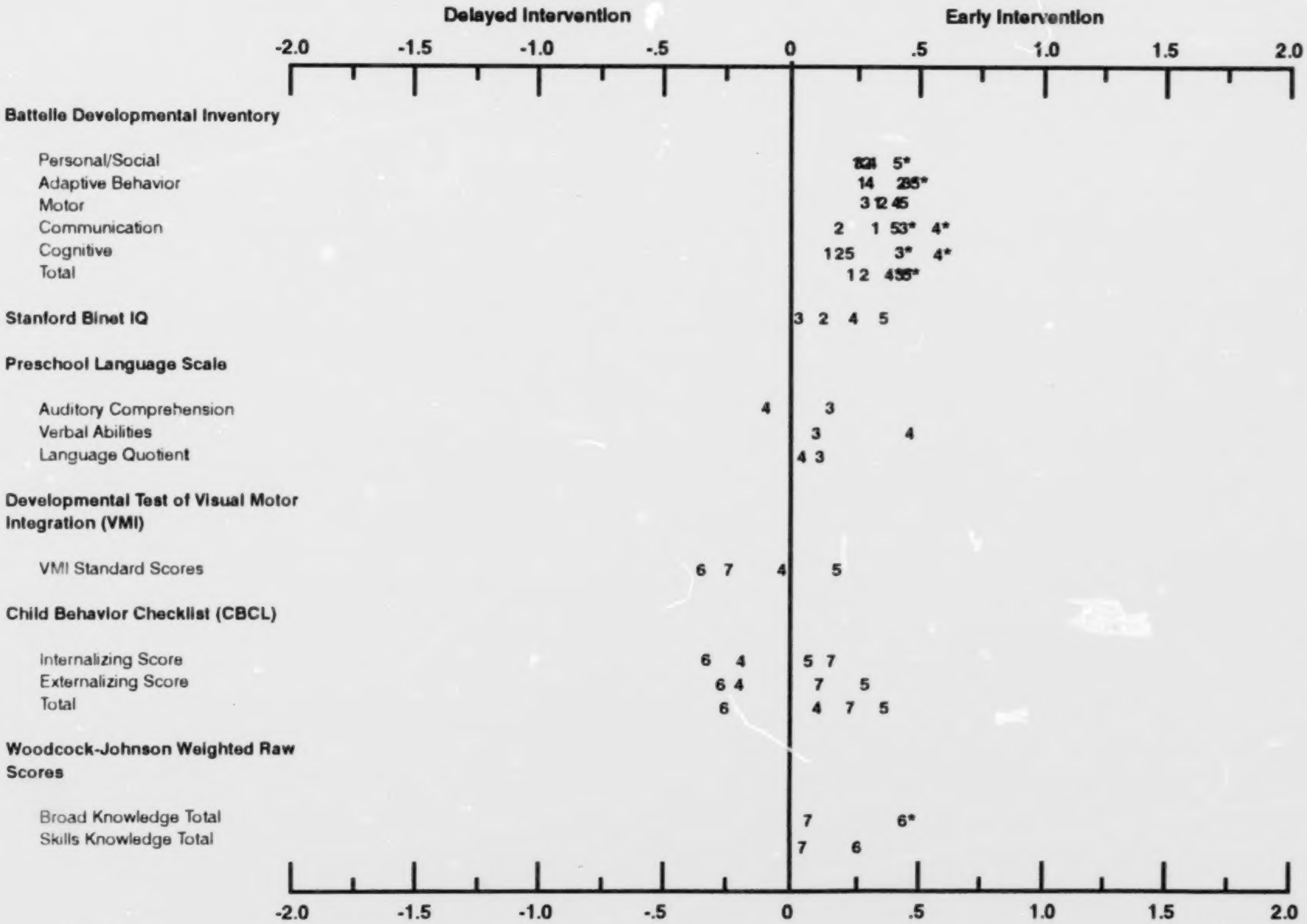


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Table 10 (continued)
Effect Sizes for Child Outcomes for the Salt Lake Medically Fragile Study

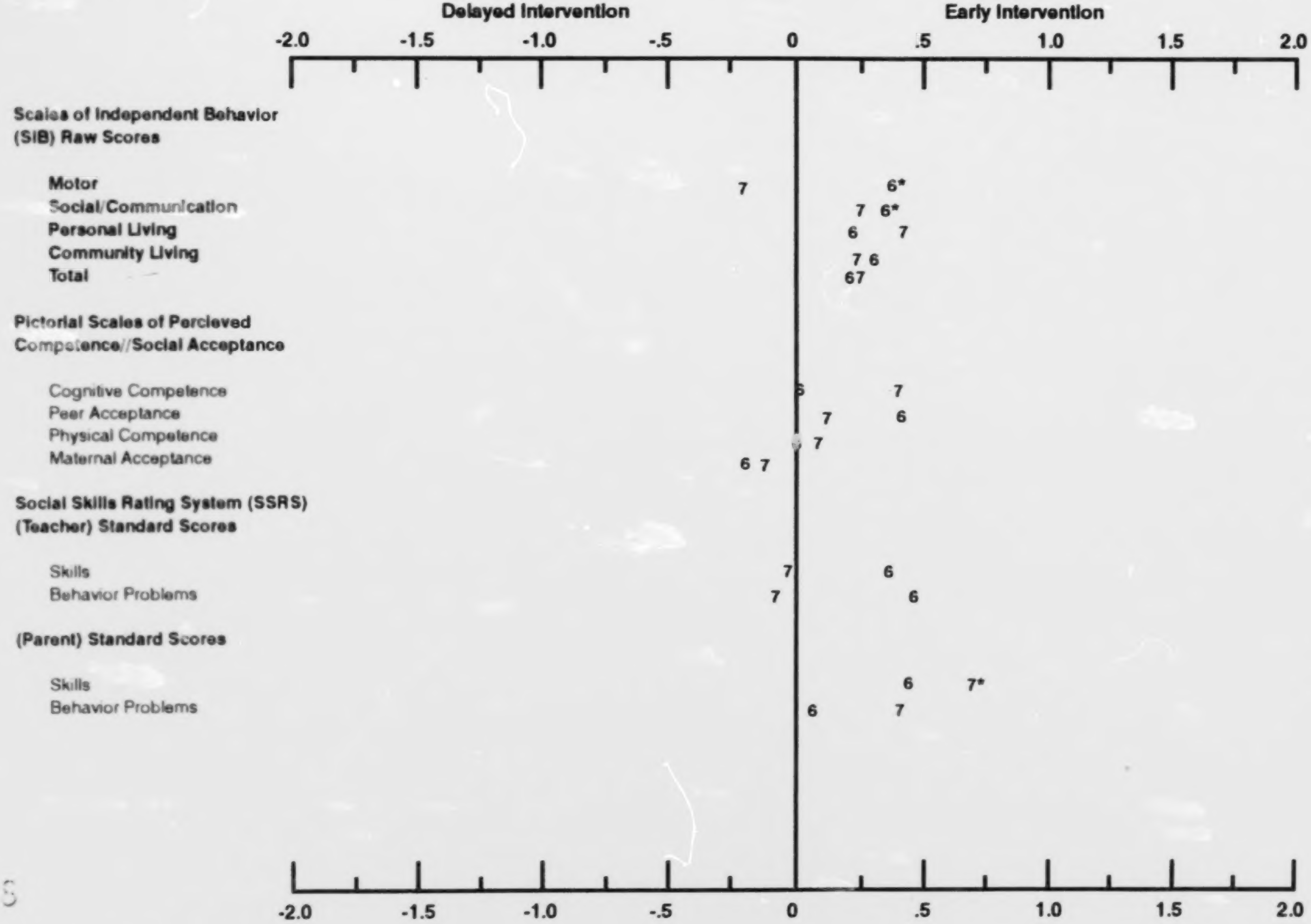
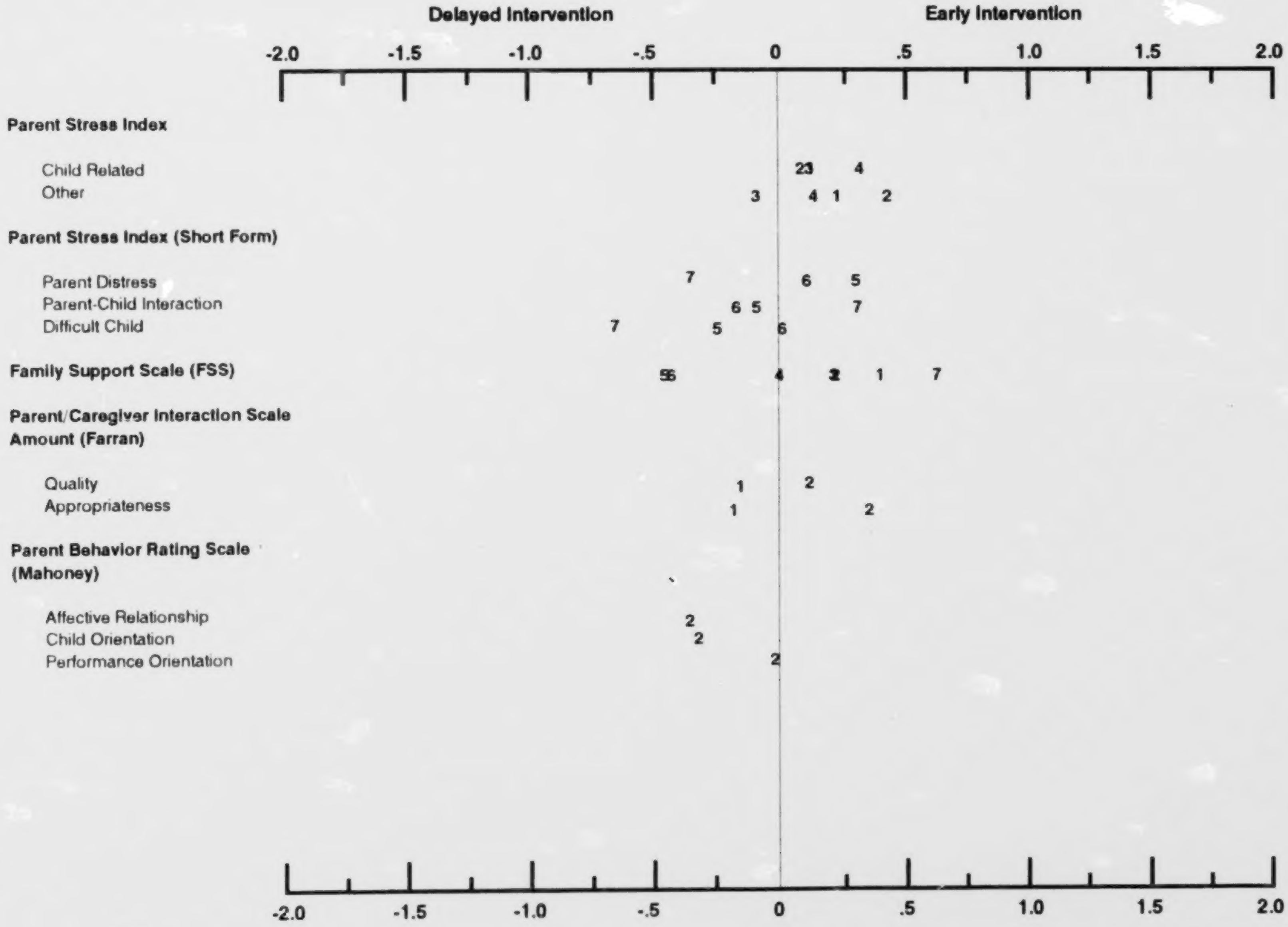


Table 11
Effect Sizes for Family Outcomes for the Salt Lake Medically Fragile Study



SOUTH CAROLINA MEDICALLY FRAGILE STUDY #6

Design

- 68 infants who were born prematurely and suffered major complications including intraventricular hemorrhage (IVH) and very low birthweight (< 1000 g), recruited in the hospital before discharge and randomly assigned to two groups.

Delayed Intervention	Early Intervention
3 Months Corrected Age	**3 Months Corrected Age**
• Medical follow-up: South Carolina Department of Health neonatal Follow-up Clinic or private physician	• Medical follow-up: South Carolina Department of Health Neonatal Follow-up Clinic or private physician
	• Sensorimotor intervention – Registered physical/occupational therapist – Curriculum and Monitoring System (CAMS) Motor Program – 1:1 child/therapist ratio – Parent instruction – Monthly to weekly visits – Home-and/or center-based
	• Assistance in locating community services
18 Months Corrected Age	**18 Months Corrected Age**
• Sensorimotor intervention	• Sensorimotor intervention
• Developmental intervention	• Developmental intervention
• Certified teacher	• Certified teacher
• CAMS curriculum (emphasis on receptive and expressive language, social-emotional, and self-help skills)	• CAMS curriculum (emphasis on receptive and expressive language, social-emotional, and self-help skills)
• Parent instruction	• Parent instruction
• Monthly visits	• Monthly visits
• Home- and/or center-based	• Home- and/or center-based
• Assistance in locating community services	• Assistance in locating community services

Table 12
Effect Sizes for Child Outcomes for the South Carolina Medically Fragile Study

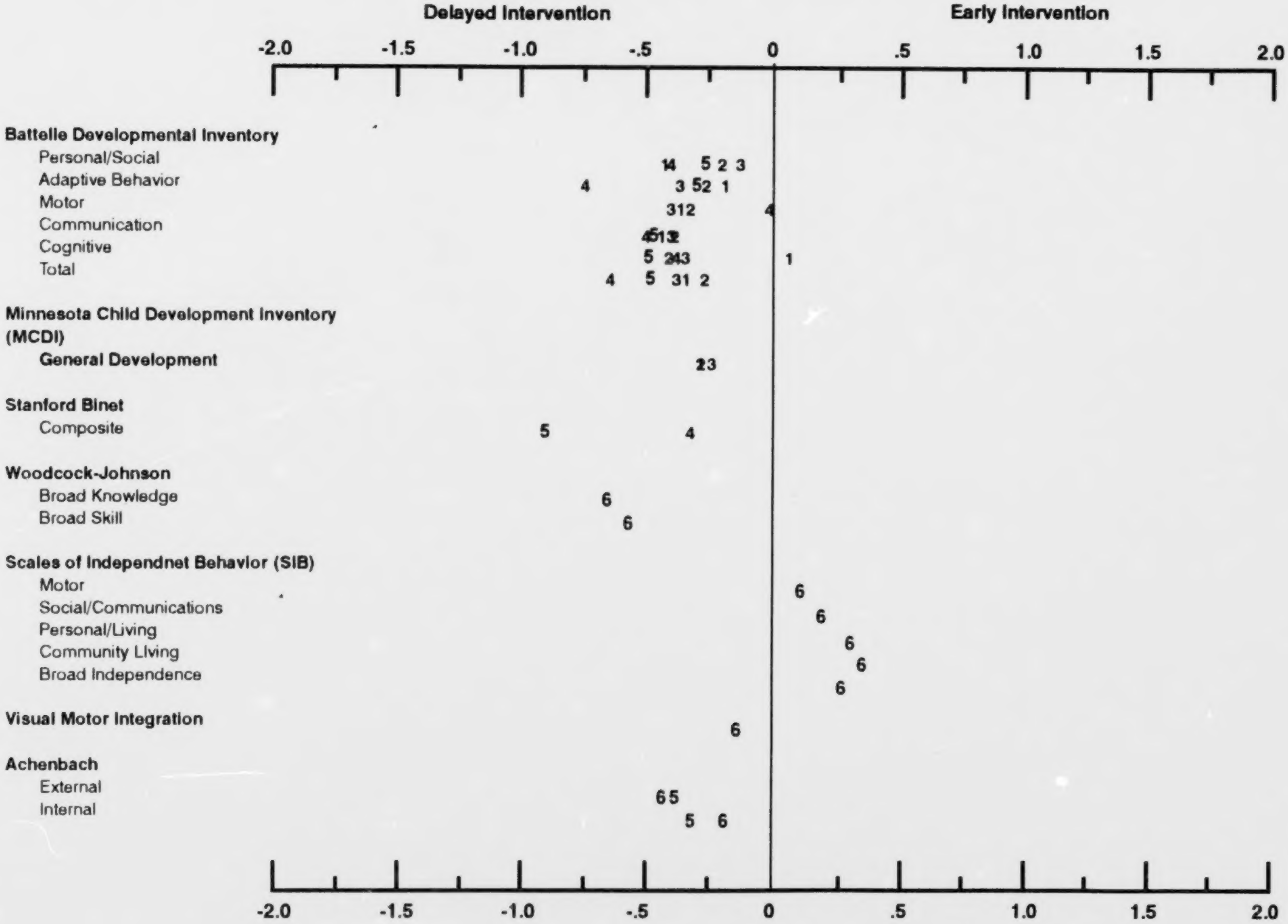
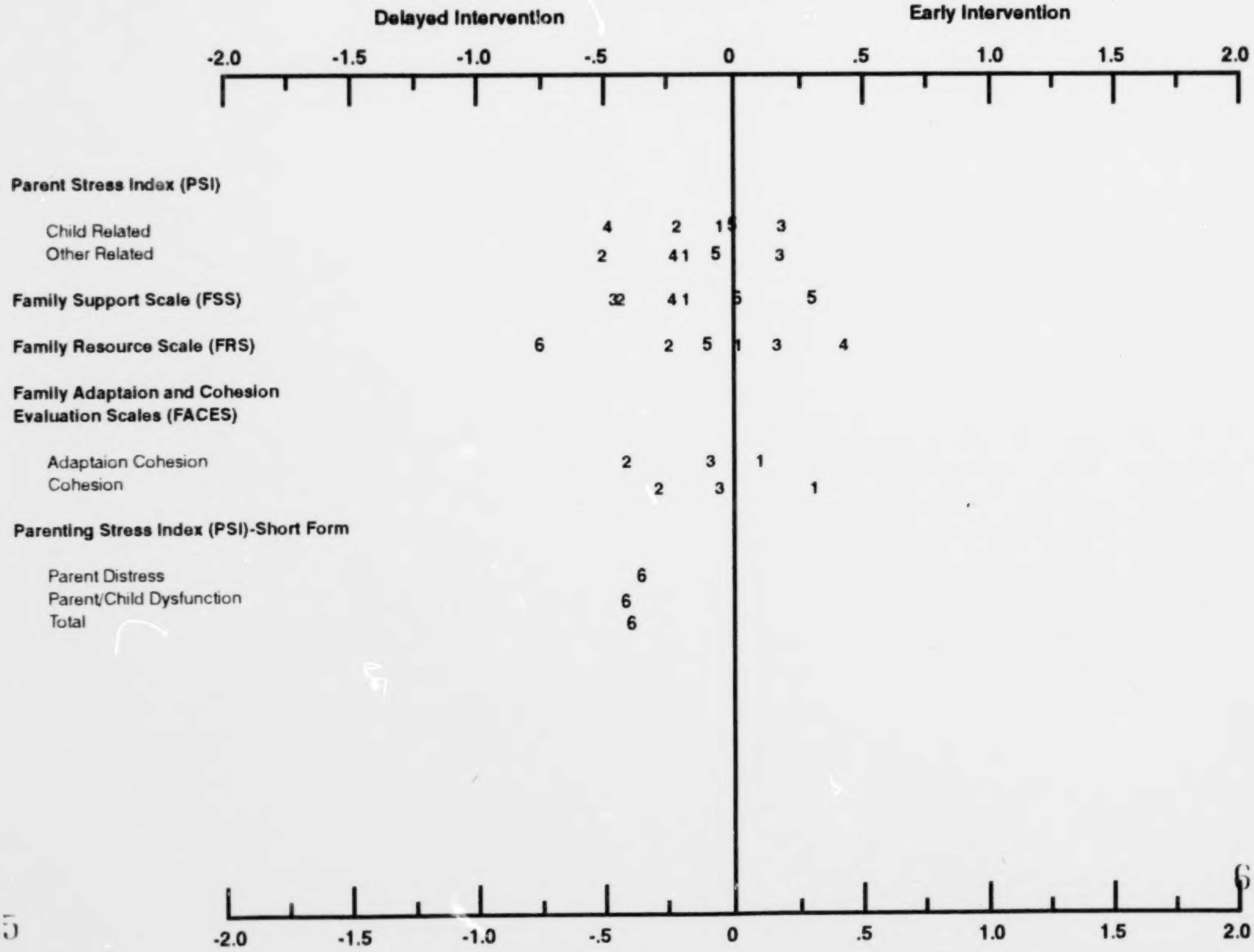


Table 13
Effect Sizes for Family Outcomes for the South Carolina Medically Fragile Study



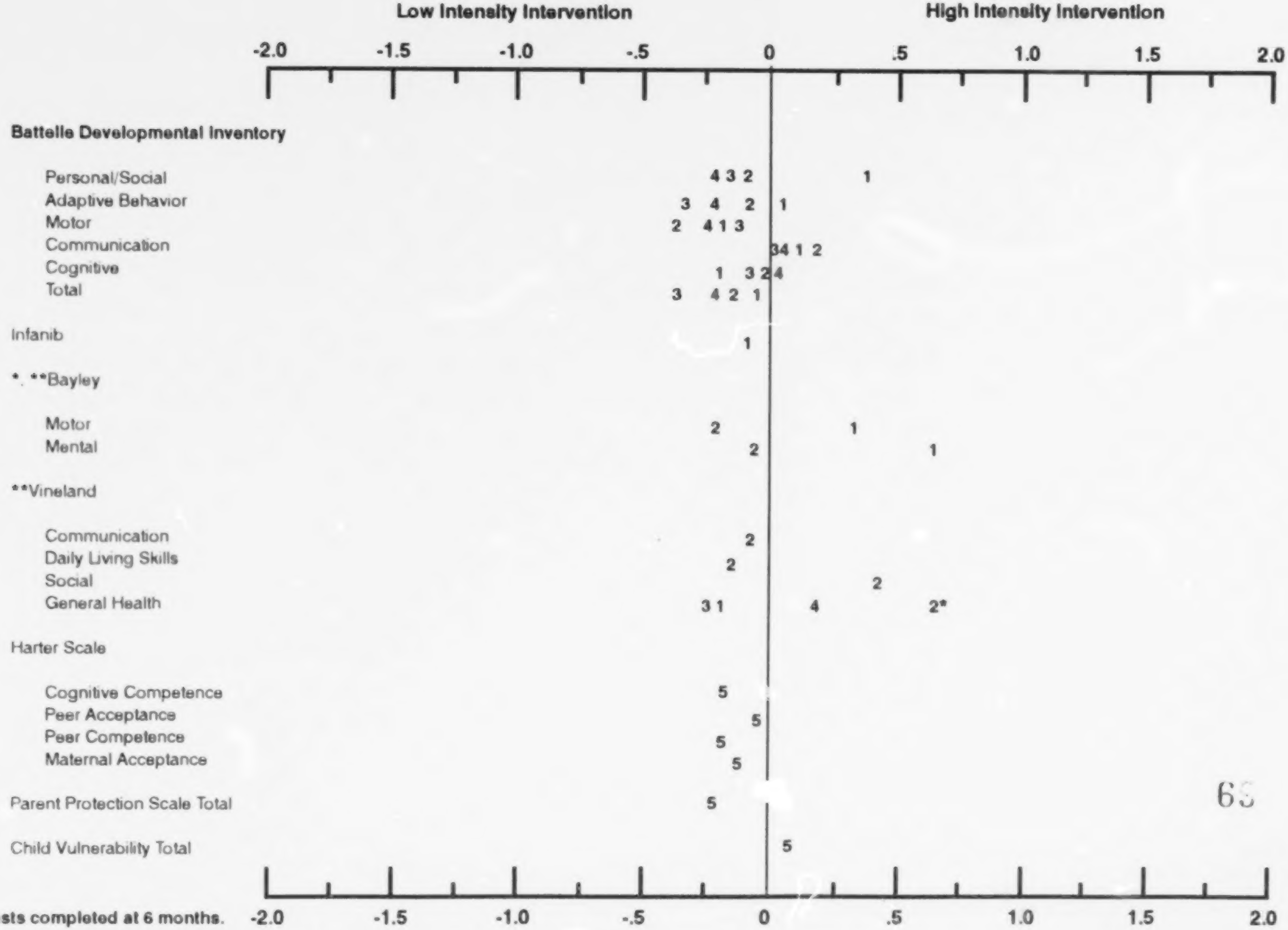
COLUMBUS MEDICALLY FRAGILE STUDY #7

Design

- 50 infants diagnosed with bronchopulmonary dysplasia (BPD) or neurological damage randomly assigned to two intervention groups.

Low Intensity Intervention	**High Intensity Intervention**
• Medical and developmental follow-up through NICU follow-up clinic	• Medical and developmental follow-up through NICU follow-up clinic
• Referral to community services	• Transition services from NICU to home-based community services -- Predischarge hospital visits -- Referral to local collaborative group -- Collaborative home visits from local providers
	• Coordinated interdisciplinary early intervention services based on IFSPs -- Nursing and medical -- OT/PT -- Developmental -- Social Services -- Medical technology personnel
• Referral to local school district or MR/DD programs at age 3	• Referral to local school district or MR/DD programs at age 3

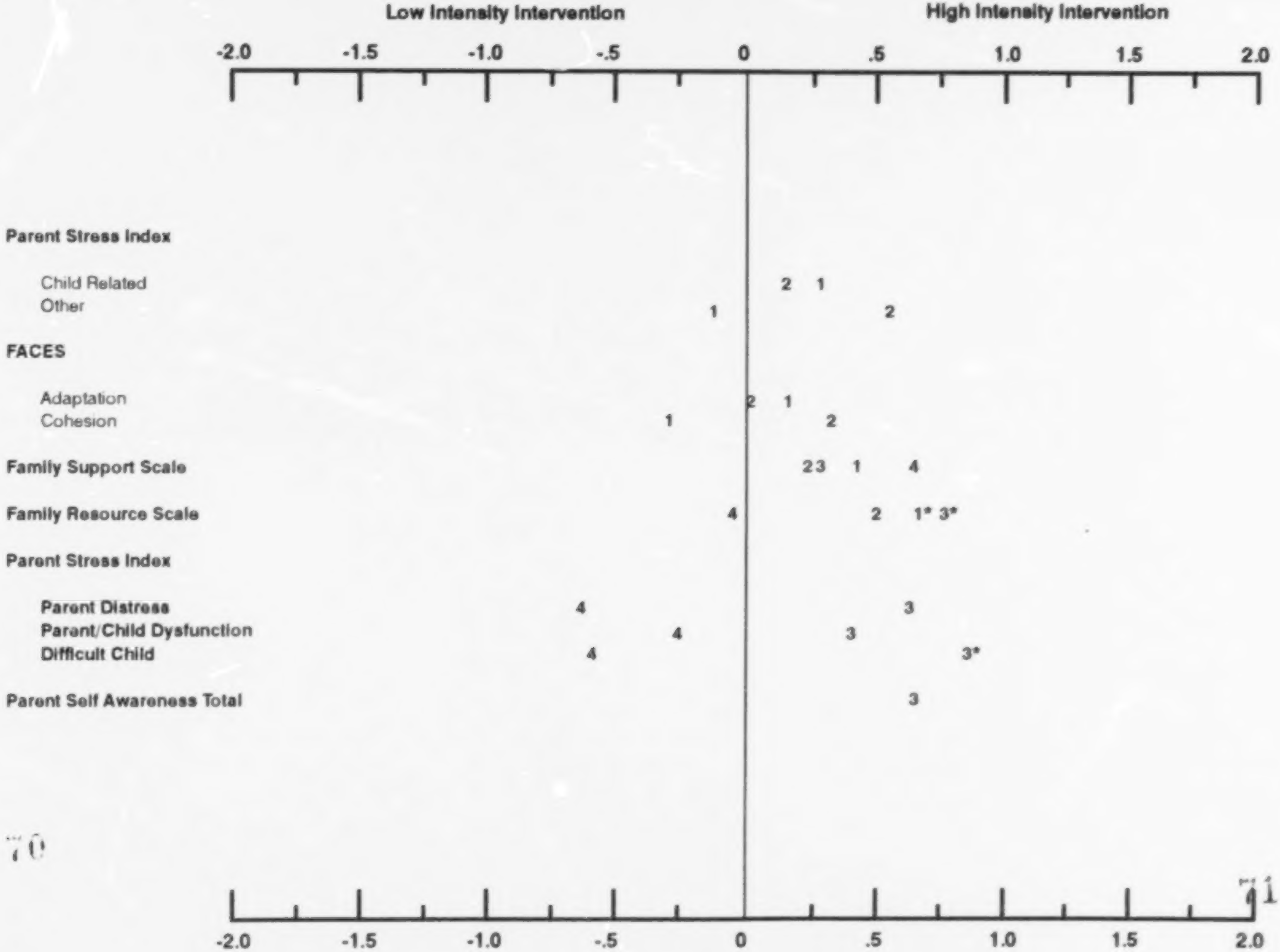
Table 14
Effect Sizes for Child Outcomes for the Columbus Medically Fragile Study



* Tests completed at 6 months.

** Tests completed at 18 months.

Table 15
Effect Sizes for Family Outcomes for the Columbus Medically Fragile Study



DES MOINES PARENT INVOLVEMENT STUDY #8

Design

- 76 children with mild to severe disabilities randomly assigned to two intervention groups.

Center-Based Intervention	Center-Based Intervention + P.I.E. Curriculum
• 5 days per week; 2½ hours per day	• 5 days per week; 2½ hours per day
• 10 children per class	• 10 children per class
• Certified teachers by aides	• Certified teachers by aides
• 5:1 child/teacher ratio	• 5:1 child/teacher ratio
• Therapists in class 1 time per week	• Therapists in class 1 time per week
• Intervention based on IEPs using variety of curricula. Emphasis on motor, language, self-help, social skills, and cognitive development	• Intervention based on IEPs using variety of curricula. Emphasis on motor, language, self-help, social skills, and cognitive development
	P.I.E. I
	• Parents attended 16, 2-hour sessions approximately once per week.
	• Sessions emphasized: -- Training in teaching/management skills -- Information exchange -- Social support and networking
	• Each parent selected and implemented an individually tailored intervention with their child (15 minutes/day, 3-5 times per week)
	P.I.E. II (for subjects receiving 2 years of intervention)
	• Developed based on parent needs assessment
	• Consisted of 12 2-hour sessions
	• Sessions emphasized: -- Information exchange -- Family support -- Social Support

Table 16
Effect Sizes for Child Outcomes for the Des Moines Parent Involvement Study

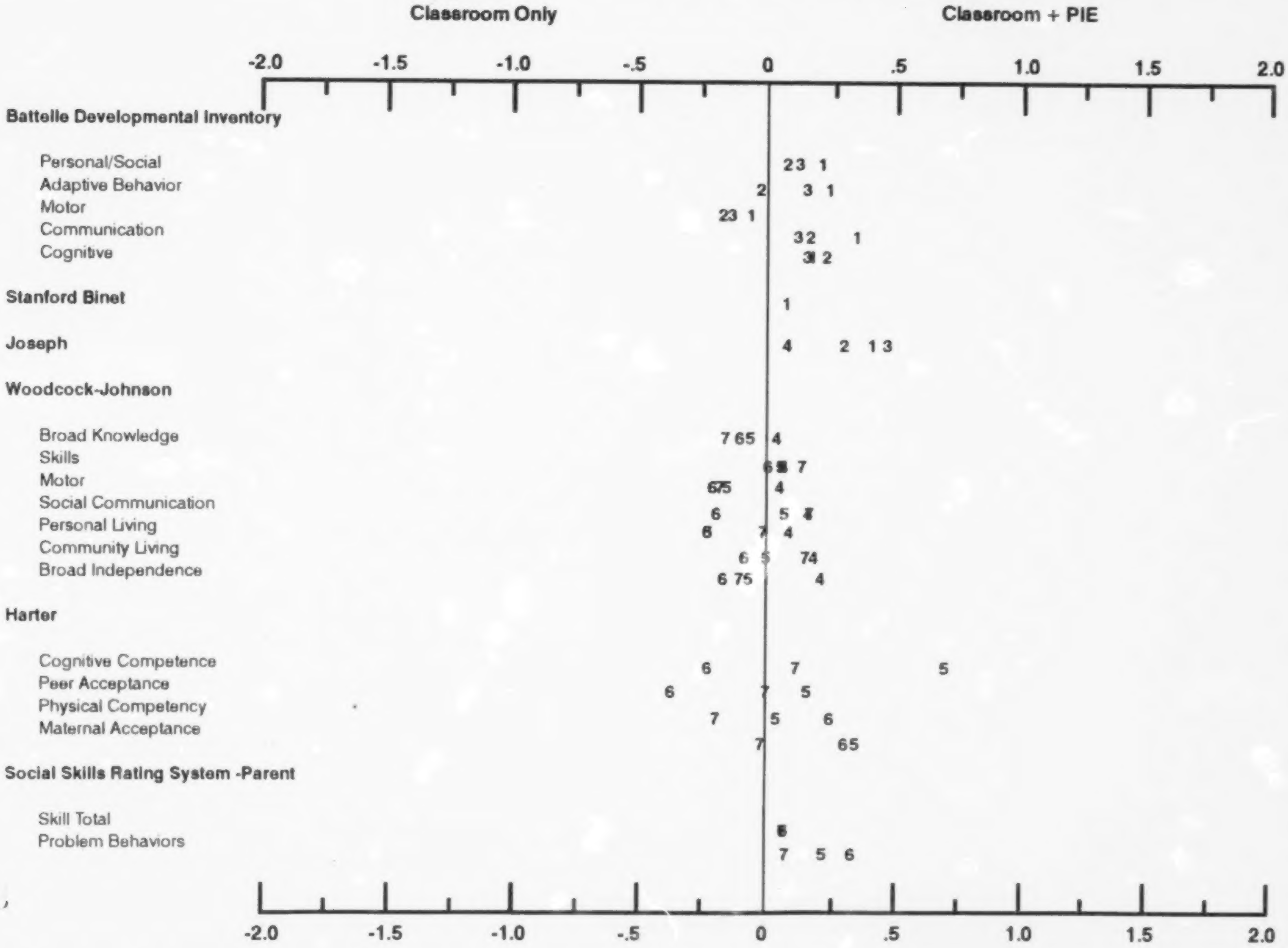
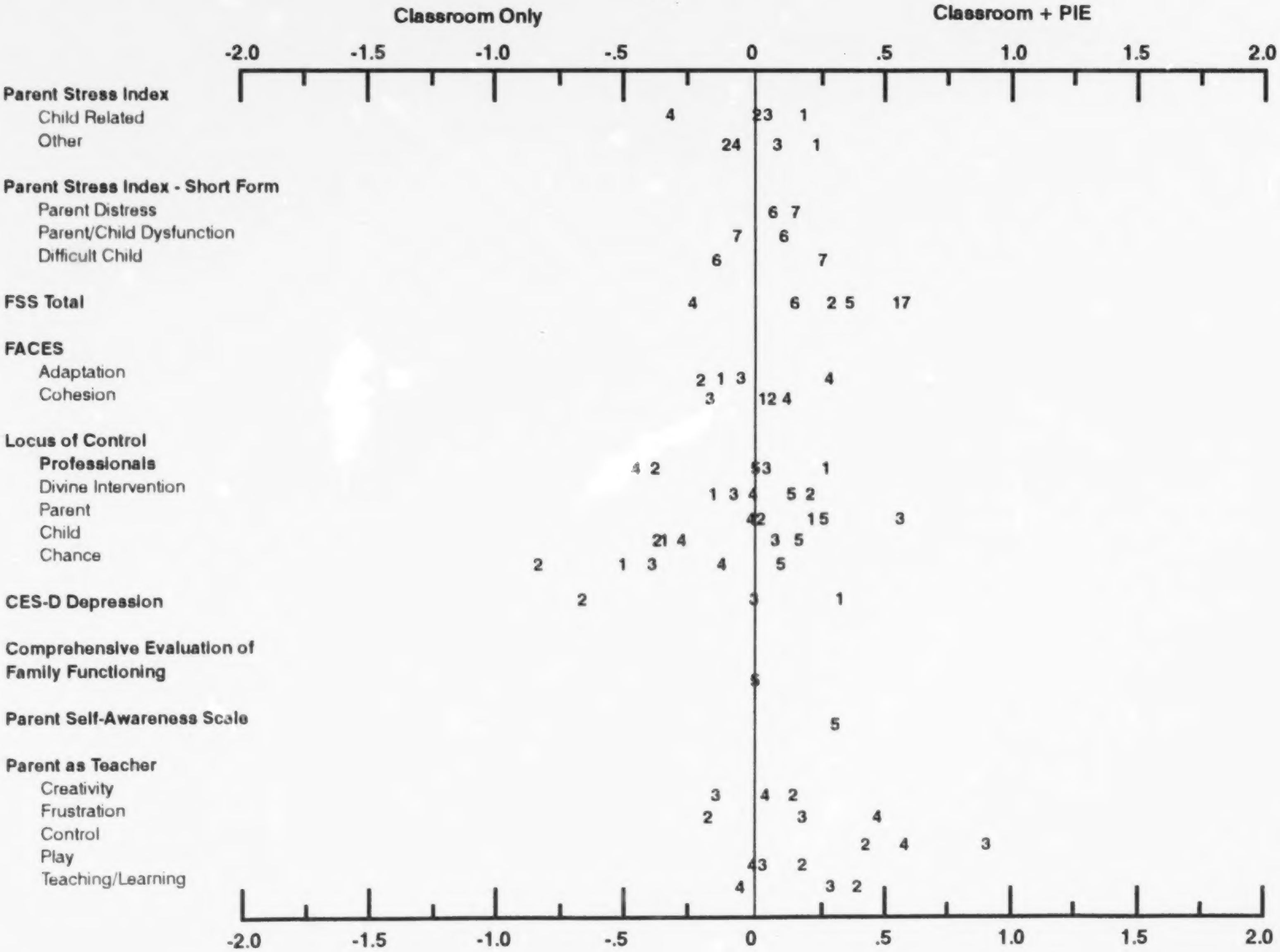


Table 17
Effect Sizes for Family Outcomes for the Des Moines Parent Involvement Study



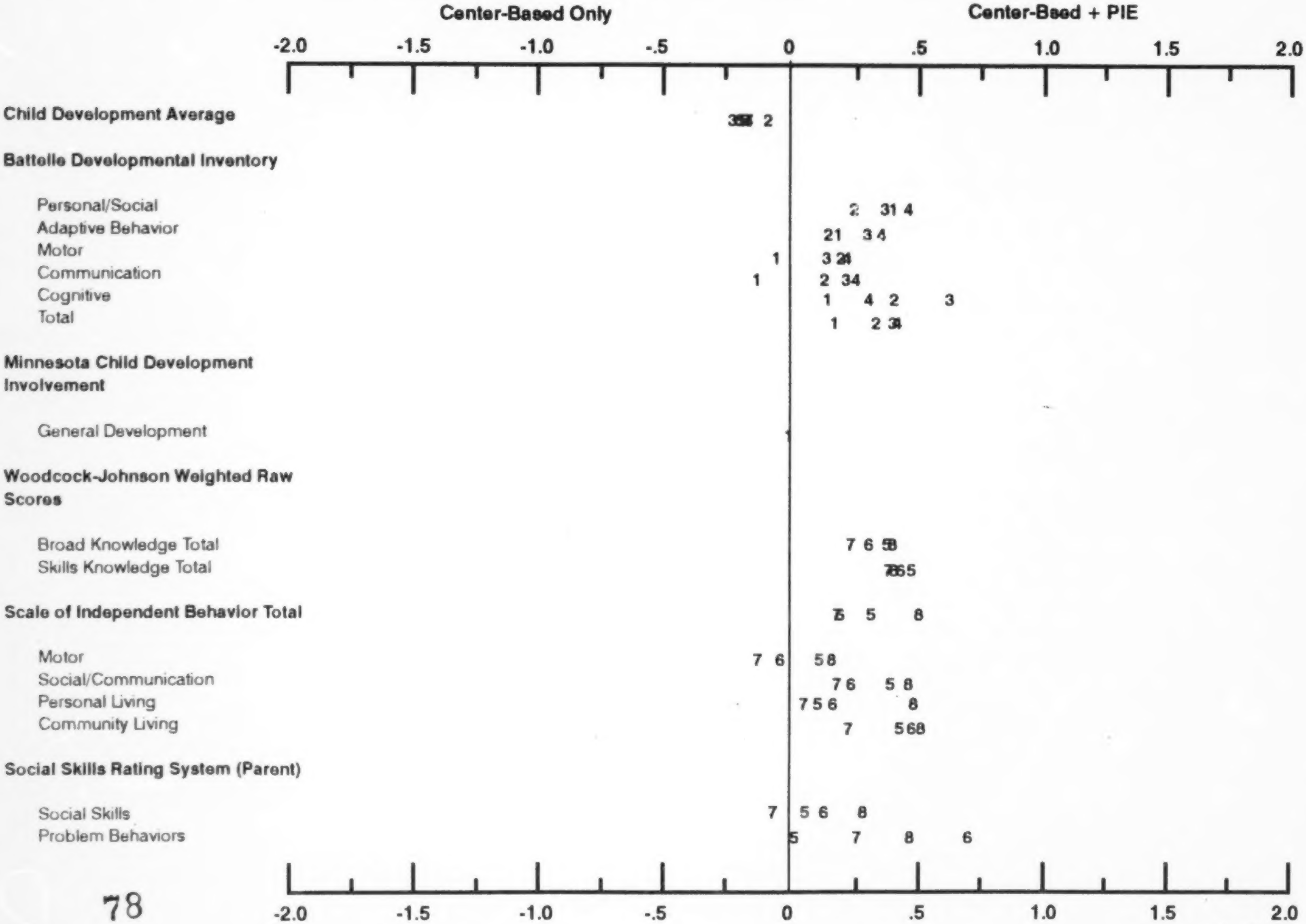
UTAH PARENT INVOLVEMENT STUDY #9

Design

- 58 children with mild to severe disabilities randomly assigned to two intervention groups.

Center-Based Intervention	Center-Based Intervention + P.I.E. Curriculum
● 5 days per week; 3 hours per day	● 5 days per week; 3 hours per day
● 10 children per class	● 10 children per class
● Certified teachers by aides and therapists	● Certified teachers by aides and therapists
● 3.6:1 child/teacher ratio	● 3.6:1 child/teacher ratio
● Therapists in class 1 time per week	● Therapists in class 1 time per week
● Intervention based on IEPs using variety of curricula. Emphasis on motor, language, self-help, social skills, and cognitive development	● Intervention based on IEPs using variety of curricula. Emphasis on motor, language, self-help, social skills, and cognitive development
	● Parents attended 15 2-hour instructional sessions discussing: -- Observation of child behavior -- Defining and measuring behavior -- Theories of child development -- Criterion-referenced assessment -- Understanding 94-142 and IEPs -- Successful intervention strategies -- Selecting and implementing interventions -- Communicating with professionals -- Stress management
	● Social support and networking component
	● Each parent selected and implemented an individually tailored intervention with their child (15 minutes per day, 3-5 times per week)

Table 18
Effect Sizes for Child Outcomes for Utah Parent Involvement Study



(continued)

Table 18 (continued)
Effect Sizes for Child Outcomes for the Utah Parent Involvement Study

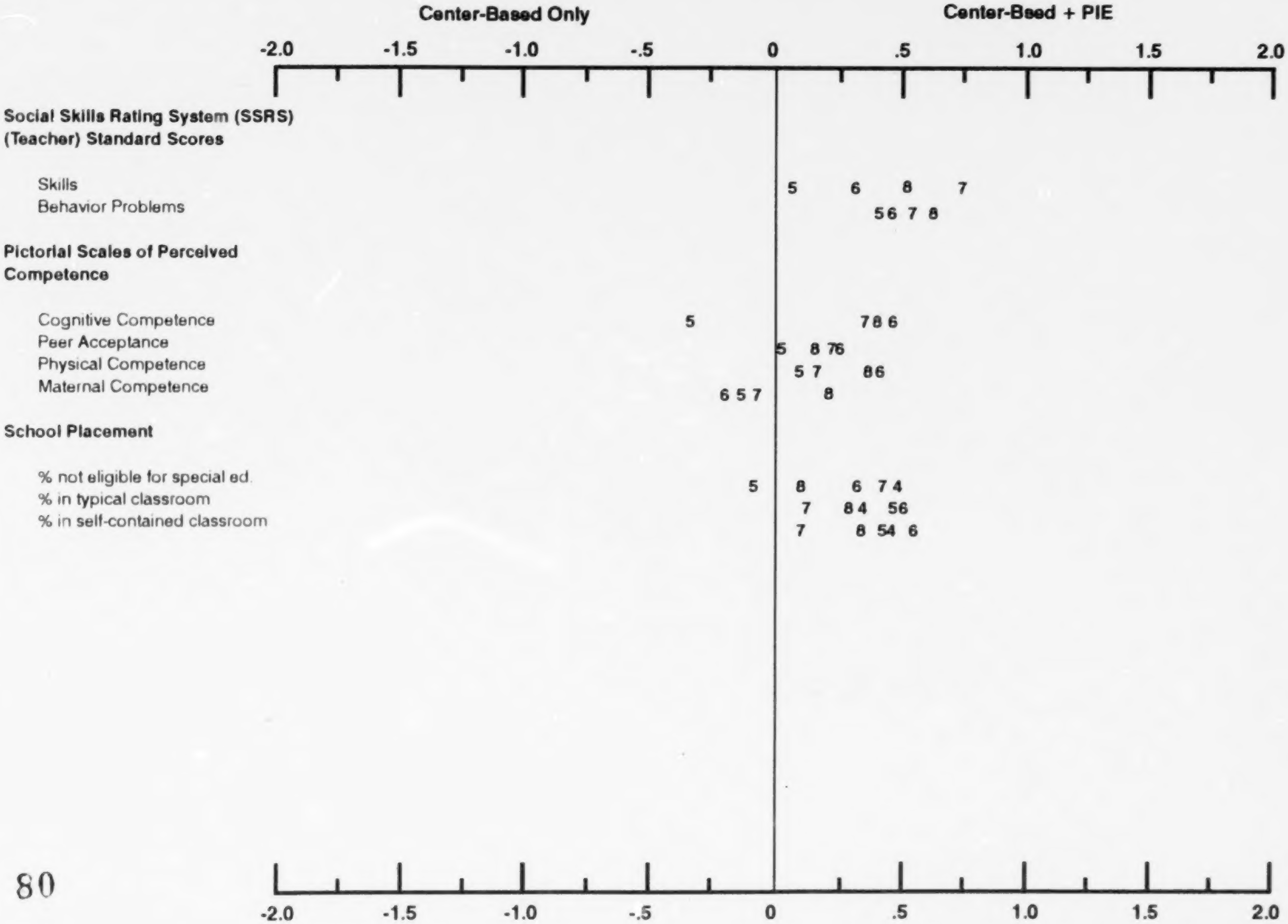
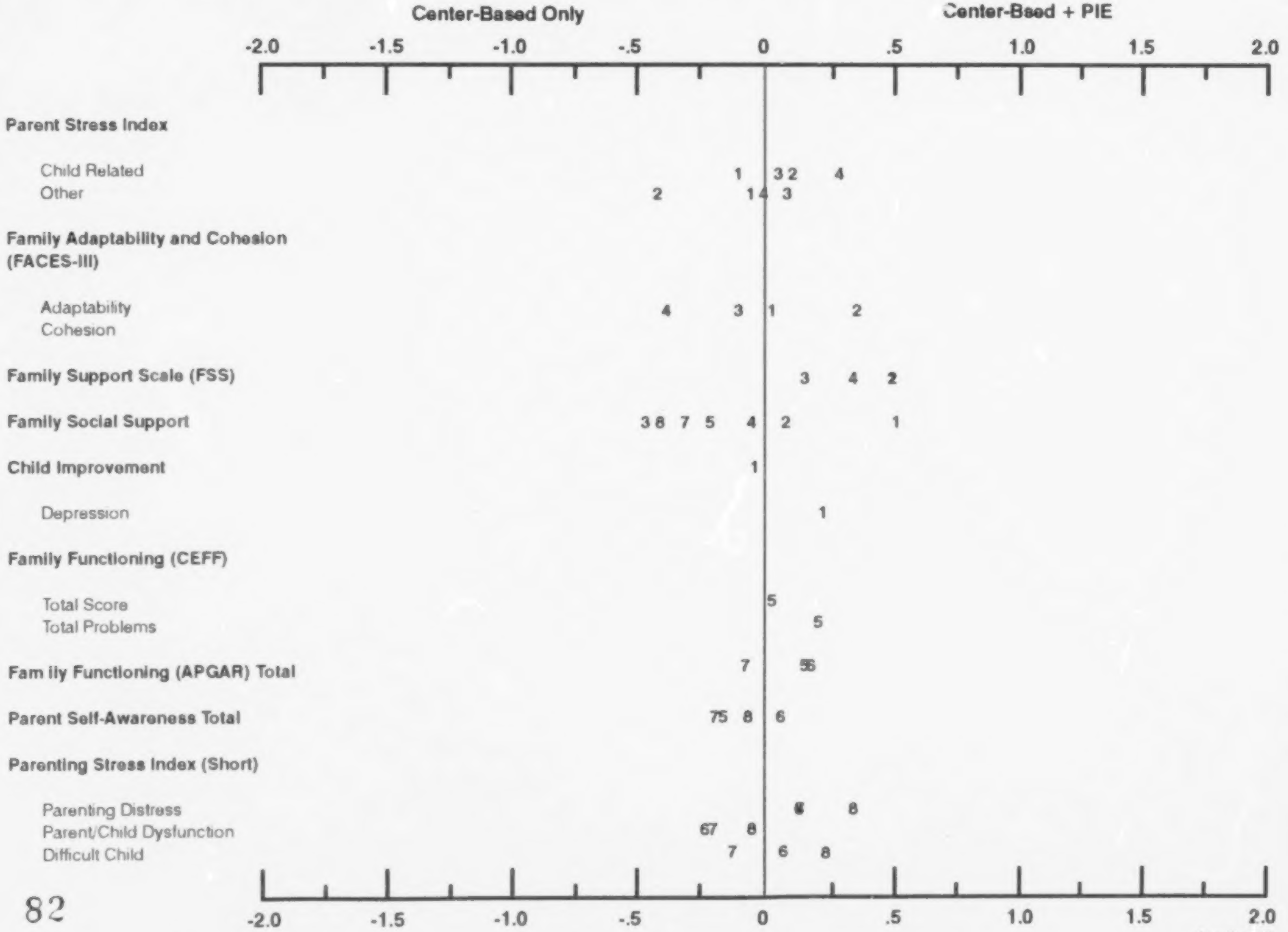
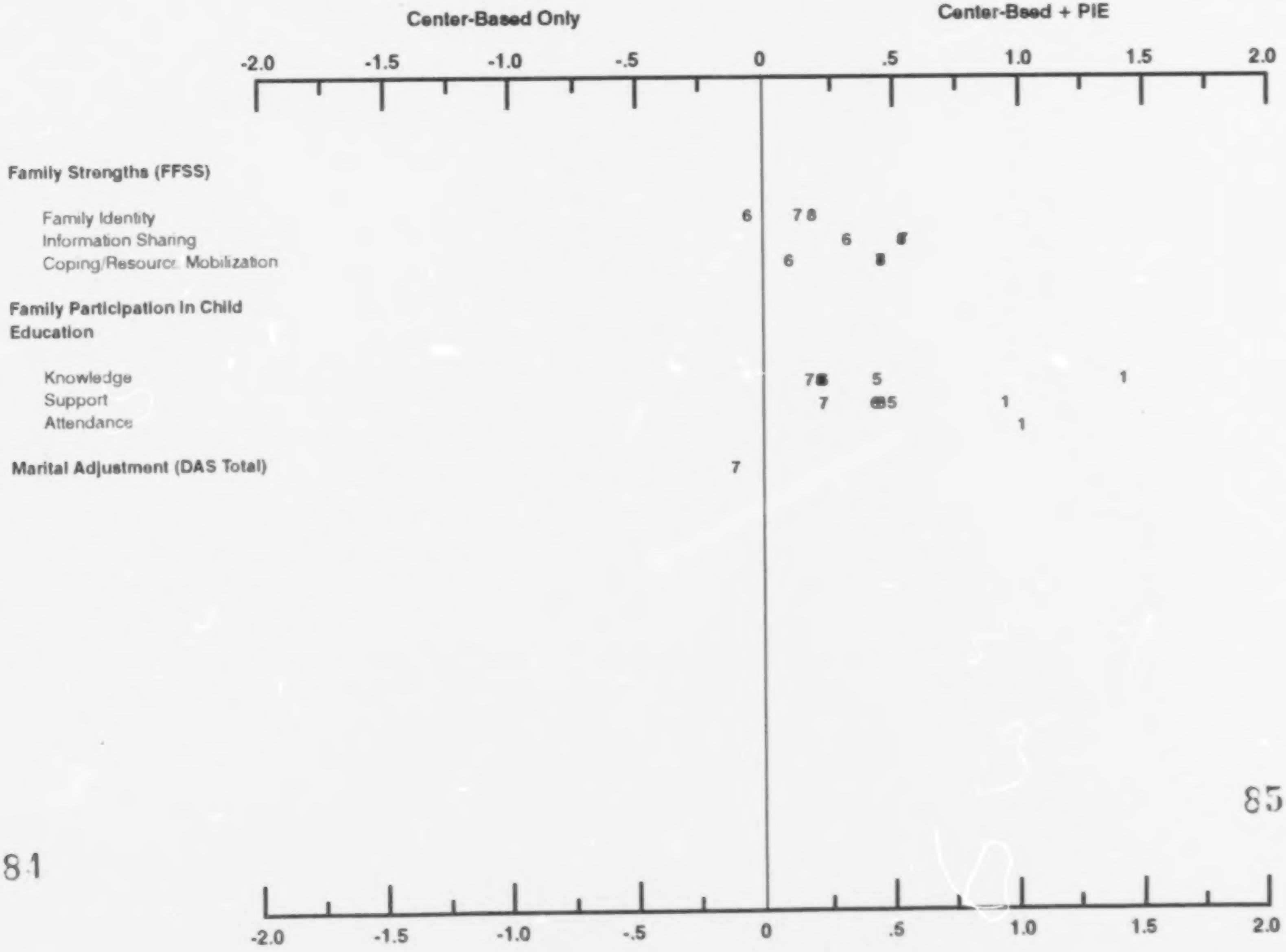


Table 19
Effect Sizes for Family Outcomes for the Utah Parent Involvement Study



(continued)

Table 19 (continued)
Effect Sizes for Family Outcomes for the Utah Parent Involvement Study



INDIVIDUAL SITE REPORTS

New Orleans Visual Impairment Study
SMA/Lake McHenry Intensity Study
Arkansas Intensity Study
Jordan Intensity Study
Salt Lake City Medically Fragile Study
South Carolina Medically Fragile Study
Columbus Medically Fragile Study
Des Moines Parent Involvement Study
Utah Parent Involvement Study

NEW ORLEANS VISUAL IMPAIRMENT STUDY (NO/VI)

Project #1

COMPARISON: Children with Visual Impairments -- Weekly individualized parent-infant sessions versus parent group meetings.

EIRI COORDINATOR: Diane Behl

LOCATION: New Orleans, Louisiana

DATE OF REPORT: October 1, 1994

Rationale for Study

The importance of sight in early development is crucial (see discussions by Barraga, 1986; Ferrell, 1986; Fraiberg, 1977; and Warren, 1984). By age three, infants with visual impairments often demonstrate socio-communicative and cognitive development patterns that are quantitatively and qualitatively different from their sighted peers (Ferrell, 1986; Warren, 1984). Ferrell (1986) stated that all of these secondary disabilities are preventable; they occur because there has not been sufficient, systematic intervention given to the child and his/her family. Although such a position is logical, there is little evidence in the literature which either confirms or refutes the value of systematic intervention in alleviating these secondary disabilities (Warren, 1984).

Visual impairment also causes a disruption in the interaction between the caregiver and child. Als (1983) observed that the infant with visual impairments signals and communicates differently. These signals are often distorted and difficult to interpret, making positive, constructive interaction even more difficult for parents who often are attempting to cope with the emotions of having an infant with a disability. Rowland (1984) summarized the position of most researchers involved with children with visual impairments by stating, "The importance of appropriate exchanges between mothers and infants cannot be overstressed."

Though the importance of early intervention for children with visual impairments and their families has been stated frequently in the literature, few controlled studies have been completed with these children, especially at the infant and toddler levels (Warren, 1984). Furthermore, even though researchers speculate that intensive intervention for both child and family is necessary, there is a dearth of evidence regarding the intensity with which this intervention should be provided. Additionally, little data are found to assist in answering the question of how to provide the best intervention (White et al., 1985-86).

This study of early intervention for infants and toddlers with visual impairments compares the immediate and long-term effects of a comprehensive, home-based intervention in the form of one time per week parent-child sessions, with a much lower intensity treatment of informal parent group meetings held approximately 12 times per year. To set the context for this study, existing research on the effects of early intervention with children with visual impairments children will first be summarized briefly. A description of this study follows, providing details of subjects and the alternative interventions, as well as the research procedures. Results based on the study to date will be presented along with conclusions.

Review of Related Research

Since 1969, 11 studies with children with visual impairments have investigated the effectiveness of early intervention. The nature of these studies, including subjects, intervention, outcome measures, and results are summarized in Table 1.1. Unfortunately, as will be discussed, critical components of well-controlled investigations were lacking.

Table 1.1

Results of Previous Studies of the Effects of Early Intervention Involving Children with Visual Impairments

Reference	Sample	Experimental Design	Description of Intervention	Outcomes Measured	Authors concluded that effects of intervention
Adelson & Fraiberg (1974)	10 infants (1-11 months), moderate/severe VI, no other disabilities	Posttest only compared to sighted controls, and VI children from earlier study	2x month home visits for 1-2 years. Emphasized child development and parent-infant interaction	Gross motor items, Bayley Scales of Development	Beneficial
Allegheny County Schools ([illegible]9)	7 preschoolers (3-5 years) "legally blind" and multiple disabilities	Pre- to posttest	5x week center-based for 6 weeks. Emphasized exploration and independence	Orientation and mobility, Body Image	Beneficial
Bregani et al. (1981)	8 infants and toddlers (8 months to 2 years) with ROP, some with multiple disabilities	Pre- to posttest	1 hour per week home visits for 1 year. Emphasized parent-child interaction	Psychomotor Development, Neurological Exam, Ocular Exams	Beneficial
Correa et al. (1984)	3 preschoolers (2 to 4 years), severe multiple disabilities, including visual impairment	Multiple baseline	20 minutes sessions 4-5 times per week for 3 months, training in reach-grasp responding conducted in a center	Reaching/grasp response	Beneficial
Fraiberg (1977)	10 "blind" infants, no other disabilities	Pre- to posttest	2x month home visits for 3 years. Emphasized parent-child interaction.	Videotaped performance	Beneficial
Harley et al. (1986)	22 infants (0 to 2 years) "blind or no useful vision," multiple disabilities	Pre- to posttest	16 weeks, some center and some home. Emphasized orientation, mobility, and child development.	Peabody Mobility, Parent Satisfaction	Beneficial
Klein et al. (1988)	22 0- to 3-year-old VI and mentally disabled	Single group, posttest only	1x week for 6 months, then 1x month for 6 months. Emphasized social skills, parental support, and interaction.	Interactional data	Beneficial
Montgomery Public Schools (1988)	27 VI preschoolers, mean age of 12 months, no other disabilities	Pre- to posttest	Combination home- and center-based services for 2 years. Emphasized child development.	Battelle Developmental Inventory, Family Satisfaction	Could not be determined
O'Brien (1976)	33 mild to severe VI, birth to 8 years	Pre- to posttest	Home- or center-based for 8 months. Emphasized child development.	Visual Efficiency Scale, Self-Concept Boehm test of Basic Concepts	Beneficial
Olson (1983)	15 VI, 2-6 year olds, no other disabilities	Posttest only compared to sighted controls	Home or school intervention for average of 2.7 years. Emphasized child development.	Performance ratings by teachers behavior	Beneficial
Rogow (1982)	10 children, 1-7 years with multiple disabilities, including visual impairments	Pre- to posttest	Home (30 minutes per day) or school (90 minutes per week) intervention for 10 months. Emphasized language development.	Language development	Beneficial

Adapted from Olson, M. (1987). Early intervention for children with visual impairments. In M. J. Guralnick & F. C. Bennett (Eds.), The effectiveness of early intervention for at-risk and handicapped children (pp. 318-321). Orlando, FL: Academic Press.

As can be seen in Table 1.1, one of the most serious problems with past research is the lack of appropriate comparison groups; the visually impaired subjects were typically compared to either normally sighted peers or a blind comparison group from a previous study. The current study improved upon these research designs by using random assignment of a sample of children with visual impairments to one of two treatment conditions. In addition to lacking appropriate comparison groups, the conclusions of these previous studies are difficult to interpret because very little demographic information is presented about participating subjects (i.e., it is difficult to know whether subjects who come from families with high socioeconomic status respond differently to intervention than subjects who come from families with low socioeconomic status, or whether subjects who are more severely visually impaired respond differently than those who have moderate visual impairments). Because of the extensive demographic data collected as a part of this study, such questions can be examined.

Another point relative to previous research is that exemplary services designed for children with visual impairments have generally been described as needing to be comprehensive in nature, providing systematic instruction to the child as well as providing parents with instructional strategies and support. Unfortunately, most previous studies have not provided clear descriptions of their interventions and have not verified that the intended interventions were actually delivered. The lack of information about the expertise of the intervenors, specific training techniques, curricula, and shaping procedures has made it difficult to understand the comprehensiveness of previous treatments as well as making it difficult for others to replicate the interventions (Guralnick & Bennett, 1987). The collection of treatment verification, described more fully in a subsequent section, provides specific information about the nature of the interventions used in this research.

As a third point, the majority of previous studies have also failed to measure critical outcomes that may have been affected by the intervention. Using a family-focused approach, the instruments used in this study are sensitive to the effects of the child on the total family, the effects of the family on the child, and the effects of external supports on the child and family. Thus, this study will provide important assessment data that have been missing from previous studies (see Table 1.1).

Another common methodological weakness of these studies is the absence of diagnosticians who are naive to the research. This has been well documented in the literature as one of the most serious methodological weaknesses, resulting in potentially biased results. This study employed diagnosticians naive to subject assignment as well as the details of the intervention.

All of the studies which reported findings concluded that early intervention resulted in substantial benefits for participating children. However, the methodological weaknesses must be considered when interpreting the results. For example, past studies have been based on very small sample sizes, or single-subject designs. Although such research methods are valuable, further replication is needed to verify the findings. The sample size of the study described in this report is relatively small in comparison to most generic early intervention studies; however, it is larger than other studies which have been conducted with children with visual impairments. Additionally, 4 of the 11 studies cited involved subjects with substantial multiple disabilities. More studies are required to investigate the effects of intervention on children who are primarily visually impaired. The study which is described in this report recruited children who were primarily visually impaired with no other severe organic disabilities (e.g., hearing or physical impairments).

Longitudinal data are also needed to determine whether effective early intervention programs continue to have a noticeable effect on children as they get older (Warren, 1984). Though five of the eight previously cited studies with children with visual impairments had interventions that were at least eight months in duration, none of them provided information regarding long-term effects of the treatment. Since this study includes outcome data for several years following treatment, it provides some needed information concerning long-term treatment results.

Finally, this study also provides an economic perspective on early intervention. One would expect the intensive program to be more expensive. Therefore, it is important to find out if the additional costs are justified in terms of gains made by children or effects on the family. Furthermore, it is important to find out if a less expensive program such as low intensity parent group meetings may result in benefits (e.g., positive effects on family functioning) that may not be present in the more expensive program which focuses more directly on child progress. Unfortunately, very little attention has been given to cost analysis issues in previous early intervention research, particularly with children with visual impairments.

Methods

Services for children in both groups were funded by the Louisiana Office of Education. The service program was developed by a certified teacher of the visually impaired with extensive experience in service provision and research. Staff who provided direct services included special educators, a social worker, and consulting service providers who were therapists at the Human Development Center at Louisiana State University Medical Center. The program was developed for the research project and provided services to children with visual impairments and their families who otherwise would not have received services. Assistance in the identification of potential research subjects, as well as information regarding various aspects of the subject's vision (i.e., acuity, perception, and discrimination), was provided by the Louisiana State University (LSU) Eye Center.

The geographical area served included the area within a 60-mile radius of New Orleans. Other services available at that time in this area for 0- to 3-year-old children with visual impairments were limited to programs designed to serve children with developmental delays or those that provided private motor and/or speech/language therapy. Consequently, most 0- to 3-year-old children with visual impairments in this area were typically not receiving any services until they were 3 years old.

Subjects

A total of 35 children between the ages of 0 to 30 months were identified and randomly assigned to groups as of July 1, 1990. The following section describes the recruitment and random assignment procedures for the study. Demographic characteristics of children and families in each group are also summarized.

Recruitment. Subjects were identified through referrals from the LSU Eye Center and from pediatricians and ophthalmologists in the New Orleans area. Children who were identified as potential subjects were screened by either the site liaison or a teacher and therapist. Each child was classified according to visual acuity, presence of other disabilities, and developmental level as follows.

Visual acuity: 1 = blind ($\leq$ 20/2400)
2 = severely impaired with correction ($\leq$ 20/900)
3 = mildly or moderately impaired ($\leq$ 20/200)

Handicapping condition: 1 = no other handicapping condition
2 = presence of one or two other mild handicaps
3 = more than two other mild or severe handicaps

Developmental level: 1 = no more than a 33% delay in motor or socio-communication/cognitive areas
2 = more than 33% delay in either motor or socio-communication/cognitive areas
3 = more than 33% delay in both motor and socio-communication/cognitive areas

The presence of an additional disability was determined by the clinical judgment of qualified motor therapist and/or communication disorders specialist. Developmental level was obtained through the use of a screening instrument that consisted of selected items from the Early Intervention Developmental Profile (Brown et al., 1981). Children were eligible for inclusion in the study if the vision impairment was the major disability and the delays were due primarily to their vision impairment. Children who had more than two other disabilities and who had more than a 33% delay in both motor and socio-communication/cognitive areas were not eligible for enrollment in the study.

As seen in Table 1.2, approximately 2/3 of the subjects had mild vision impairments (between 20/200 and 20/900), with the remaining 1/3 distributed in moderately and severely visually impaired groups. The majority of subjects for both groups were rated as having no additional disability and/or significant developmental delay.

Table 1.2

New Orleans VI Intensity Study Subjects' Degree of Vision and Severity of Handicaps

	Low Intensity	High Intensity
Severe Vision Impairment ≤ 20/2400	17%	22%
Moderate Vision Impairment ≤ 20/900	11%	11%
Mild Vision Impairment ≤ 20/200	72%	67%
Handicapping Condition/Developmental Delay:		
No additional disability/ developmental delay	67%	56%
1-2 mild-moderate disability/ developmental delay	33%	44%

The most frequently-occurring causes of vision impairment for subjects were optic atrophy (10%), retinopathy of prematurity (31%), and albinism (17%); other etiologies were present in smaller numbers.

Assignment to groups. After receiving a signed informed consent form from parents, children were randomly assigned to groups stratified by visual acuity, and a combined score for disability and developmental level. (Refer to the EIEI 1986-1987 report for a more detailed description of the assignment procedures). An initial group of 15 children identified during screenings in the first two weeks of February were rank-ordered by age within the cells. A random assignment pattern was determined for each cell by a computer-simulated four-sided die. Children were assigned based on this pattern within cells. Children who were identified after that date were placed in the appropriate cell and assigned according to the assignment pattern.

Demographic characteristics. Demographic pretest data on all subjects enrolled as of July 1, 1990, are reported in Table 1.3. The population from which children were drawn was about 80% Caucasian and had a high degree of variability with respect to socioeconomic status. Although not statistically significant, there were some differences between groups (e.g., hours per week the mother was employed, with mothers in the low intensity group working more hours; and percent of children in daycare, with more children in the high intensity group being in extended care). Some demographic data related to the father are missing due to single parent families with estranged fathers.

Demographic data collected at the time of each reassessment were analyzed to determine if there were any changes between groups over time. Such differences would then be considered as covariates when analyzing the reassessment data.

No significant differences were found between the low- and high-intensity groups for any of the demographic variables analyzed for reassessments 1, 2, and 3. Some overall changes in demographic characteristics of the sample as a whole were noted over a three-year period.

Although years of father's education remained the same, years of mother's education rose for the low intensity group from 13.0 to 13.4 years, and for the high intensity group from 12.9 to 13.7 years. Changes in hours/week spent in employment by father and mother had also increased. With this increase came increases in mean household income, from $25,265 to $31,266 for the low intensity group and from $25,000 to $34,136 for the high intensity group. Also, the percent of mothers and fathers employed in positions categorized as technical/managerial or above had

Table 1.3

Comparability of Groups on Demographic Characteristics for NO/VI Intensity Study: All Subjects Enrolled by August 1, 1990

	Low Intensity			High Intensity				
	$\bar{x}$	SD	n	$\bar{x}$	SD	n	p Value	ES^
• Age of child in months at pretest	14.5	(10.0)	17	12.3	(11.7)	18	.57	-.22
• Age of mother in years	25.5	(4.3)	17	27.3	(6.5)	17	.36	.42
• Age of father in years	31.4	(8.7)	15	33.3	(10.4)	16	.60	.22
• Percent Male*	41%		17	56%		18	.44	.25
• Years of Education--Mother	13.0	(1.8)	17	12.9	(2.6)	18	.94	-.06
• Years of Education--Father	13.3	(2.9)	14	13.1	(3.1)	17	.88	-.07
• Percent with both parents living at home	71%		17	83%		18	.43	.26
• Percent of children who are Caucasian*	76%		17	83%		18	.66	.15
• Hours per week mother employed	16.9	(18.9)	17	7.8	(15.9)	18	.13	-.48
• Hours per week father employed	40.8	(15.7)	10	39.3	(19.5)	16	.83	-.10
• Percent of mothers employed as technical managerial or above*	35%		17	11%		18	.12	-.50
• Percent of fathers employed as technical managerial or above*	38%		13	53%		15	.49	.25
• Mean total household income' (median)	$25,265 $25,000	($17,316)	17 18	$27,139 $13,000	($27,649)	18 18	.81	.11
• Percent with mother as primary caregiver*	82%		17	89%		18	.64	.15
• Percent of children in day care more than 5 hours per day*	47%		17	18%		17	.09	-.56
• Number of siblings	.7	(.9)	17	.8	(.8)	17	.69	.12
• Percent with English as primary language'	100%		17	100%		18	1.00	0.00

Effect Size (ES) is defined here as the difference between the groups (expanded minus basic) on the $\bar{x}$ scores divided by the standard deviation of the Basic Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for more general discussion of the concept of Effect Size). The positive or negative sign of the ES only indicates direction of difference; no value judgement is intended.

* Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scored at "0."

' Means and standard deviations for this variable were estimated from categorical data.

increased. Mothers in this category increased from 35% to 50% for the low intensity group and from 11% to 20% in the high intensity group. Fathers in this category increased from 38% to 57% in the low intensity group and from 42.9% to 53% in the high intensity group. While there was a difference (although not significant) between groups for the percent of children in daycare more than five hours/week for reassessment 2 (low intensity = 47%, high intensity = 18%), this difference had decreased by the time of the reassessment 3 testing (low intensity = 42.9%, high intensity = 27.3%). The remaining demographic variables stayed relatively constant over the three-year period.

Subject attrition. Four subjects dropped prior to the collection of Year 1 posttest data; three subjects were dropped from the study based on the parent's decision to no longer participate, and one subject died following prolonged hospitalization. Thus, there were 31 active subjects at Reassessment #1. One parent temporarily dropped from participation at Reassessment #2, and one subject could not be located; thus, there were 29 active subjects at Reassessment 2 time. As of Reassessment #3, the formerly lost subject was relocated, though a different family moved without leaving a forwarding address or phone number. Additionally, two families have refused participation due to family strains. At the time of Reassessment 4, subjects could not be located in time for testing, resulting i 27 subjects. However, at Reassessment #5, 29 of the original 31 active subjects were tested, with only two declining to participate.

Data for key demographic and pretest variables for those who remained in the study and for those who dropped out of the study prior to the collection of Posttest #1 data are reported for children in each group in Table 1.4. As can be seen, those who dropped out from each group are quite similar to those who remained, except for the income variable. Since so few children have dropped out of the study, the test of statistical significance is not particularly meaningful, even though it is recorded in the table. These data seem to suggest, however, that attrition which has occurred thus far has not substantially effected the results of the study.

Table 1.4

New Orleans VI Intensity Study Attrition Comparison

		Group						ANOVA				
		Low Intensity			High Intensity			Group		Study Status		Group by Status
Variable		$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	ES	p Value	ES	p Value	p Value
CA at Pretest	IN	15.2	(9.8)	16	14.1	(12.5)	13		.62		.12	.47
	OUT	3.5	(.7)	2	9.8	(8.8)	4					
Total PSI	IN	224.4	(35.0)	16	210.4	(21.1)	13	.29	.97	.18	.80	.31
	OUT	213.5	(12.0)	2	228.5	(32.9)	4					
Education Mother	IN	13.1	(1.8)	16	12.8	(2.7)	13	-.09	.92	.29	.52	.70
	OUT	12.0	(0.0)	2	12.5	(1.7)	4					
Education Father	IN	13.4	(3.0)	13	13.1	(3.4)	11	-.14	.53	.48	.49	.67
	OUT	13.0	(1.4)	2	11.5	(1.0)	4					
Income	IN	$24,500	($17,585)	16	$28,885	($27,910)	13	-.01	.58	.55	.37	.33
	OUT	$22,250	($17,324)	2	$ 9,500	($ 4,950)	4					
FRS	IN	131.9	(10.5)	15	111.3	(22.6)	13	-.49	.03	.13	.20	.79
	OUT	140.5	(5.0)	2	124.3	(21.7)	4					
Hours Daycare	IN	3.5	(3.9)	13	1.6	(2.9)	11	-.60	.02	-.56	.06	.12
	OUT	12.0	(17.0)	2	2.5	(5.0)	4					
BDI Total DQ	IN	73.0	(26.2)	16	60.0	(27.3)	13	-.39	.98	.71	.11	.33
	OUT	63.0	(53.0)	2	69.2	(36.0)	4					

Effect Size (ES) is defined here as the difference between the groups (high intensity minus low intensity) on the x scores, divided by the standard deviation of the Low Intensity Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of effect size).

Intervention Programs

The alternative interventions were designed to be weekly individualized home-based intervention versus parent group meetings that were held approximately 12 times per year. A detailed description of the treatments follows.

High intensity weekly individualized treatment. The more intensive intervention for 0- through 30-month-old subjects consisted of weekly home-based parent-infant sessions in which parents or primary caregivers and their children received systematic individualized services to meet the needs of the family as well as the child. A home-based intervention as the high intensity treatment was chosen for use in this study for several reasons. Home-based programs serving young children who are disabled or at-risk are one of the most typical intervention models in the field (Halpern, 1984). Philosophically, there are numerous advantages to a home-based intervention and the involvement of the family. Some of the earliest advocates of home-based intervention, Shearer and Shearer (1976) argued that home-based intervention was good because:

> (1) Learning occurs in the parent and child's natural environment....(2) There is direct and constant access to behavior as it occurs naturally.... (3) It is more likely that learned behavior will generalize and be maintained....(4) There is more opportunity for full family participation in the teaching process....(5) There is access to the full range of behaviors....(6) Training of parents, who already are natural reinforcing agents, will provide them with the skills necessary to deal with the new behaviors when they occur....and (7) Because the home teacher is working on a one-to-one basis with the parents and child, individualization of instructional goals for both is an operational reality. (pp. 336-337)

There are also practical advantages to home based intervention. For rural or low-income families, travel to a center location is often difficult. Additionally, some children have medical needs that make leaving the home difficult (Bailey & Simeonsson, 1988). In spite of these theoretical and practical justifications for home-based intervention, previous research has provided very little evidence about the effectiveness of home-based intervention, particularly for children with visual impairments.

The model of home-based intervention used in this study was consistent with the guidelines set forth by P.L. 99-457 for serving the families of children ages birth through 3 years of age. A case manager coordinated the services for the family. The case manager was typically the education specialist, although this varied in accordance with the characteristics of the child and family. Individualized Family Service Plans were developed to meet needs of the child and family. All infants/toddlers in the individualized treatment group were scheduled for an average of 1 hour of intervention services weekly. In three instances, it was necessary for families to travel to the program center for intervention services. The travel expenses for these families were covered through program funds.

The Louisiana Curriculum for Infants with Handicaps, which was developed by the staff of the Human Development Center, formed the basis for development of intervention activities for the program. The activities in the curriculum take into account the total child and the interactive nature of development across domains. The activities incorporated daily routines, such as feeding, diapering and changing, as well as familiar toys and household items.

Activities (lessons) were developed for the domains of gross motor, fine motor, cognition, self-help, social-emotional, and communication. Information with each lesson included: area, goal, rationale, materials, cautions, teaching procedures, teaching notes, and evaluation criteria. A data collection system was used by parents and program staff for charting children's progress. A Curriculum Placement Instrument (CPI) for each domain was used for choosing activities appropriate for the status of child and family. Modifications were made in specific activities in the curriculum, in consultation with the professional staff, to adapt them to the child's needs and as appropriate for the child's vision.

Often parents requested information on a particular topic related to visual impairment or child development. The home intervenor provided supplemental information from the Reach Out and Teach curriculum (Ferrell, 1986). This is a manual designed to provide parents with information about visual impairments and appropriate general stimulation activities.

In addition to focusing on specific needs of the individual infant/toddlers, the needs of the family in relation to the child were addressed. Treatment reflected the family's needs in regard to interacting with the child, developing their general knowledge of visual impairments, and improving their skills in encouraging their child's development. Needs for assistance or guidance in obtaining community services such as medical or daycare services for their child were also addressed.

The person with primary caregiving responsibility for the child at the time was the active participant in the session. In instances in which a parent was not the primary caregiver during program intervention sessions, every effort was made to share information with them in telephone contacts and other visits. For example, one child attended a regular preschool, 5 days a week, and the program teacher provided services there. Meetings were held between program staff, preschool staff, and the parent to discuss and plan strategies and exchange information. All parties were pleased with this pattern of service delivery, which appeared to be the most natural setting for this child.

The degree of caregiver involvement in any one session was individualized according to the needs and skills of the caregiver. The role of the intervenor during the sessions may have been assumed almost entirely by the caregiver, with the program teacher guiding and giving feedback. In other instances, the program teacher demonstrated while the caregiver observed. In most sessions, there was a combination of these patterns. New activities were generally first introduced by the program teacher, who then instructed the caregiver in implementing the activity. Parents were involved in implementing stimulation activities, collecting data, and charting behavior in the home between sessions.

During the first year of the study (1987-1988), the education specialist was the primary contact person working closely with the parents or other caregivers to provide the intervention. The education specialist planned sessions and activities, guided interventions, collected data, maintained attendance records and individual child folders, and coordinated consultations and direct services from other professionals. These two education specialists were certified teachers experienced in serving young children with special needs. The speech therapist, occupational therapist, physical therapist and social worker from the Human Development Center at Louisiana State University assisted in meeting needs of the participating infants/ toddlers and their families. All children were seen, initially, by at least one of these specialists in the screening process. Depending upon the impairments of the child and needs of the family, the specialists were called upon for consultation with the program teacher and/or parents, or for provision of direct services. For example, the speech therapist might have assisted the teacher to design a turn-taking routine and the OT and PT might have provided direct services for children with gross and fine motor problems. During the subsequent two years, the role of the social worker was expanded to provide more direct intervention with families. The social worker maintained close contacts with the families, interacting with them 1-2 times per month. In fact, often the social worker was the case manager.

A certified teacher of the visually impaired supervised the home interventions and offered programming suggestions during 1987-1988. Intervenors were certified special education teachers. As noted by Silberman, Corn, and Sowell (1989), most states have deemed it appropriate to deliver services to children with visual disabilities by having generically trained teachers who are supervised by someone who is certified as a teacher of the visually impaired. Indeed, this model is used with the majority of children with visual impairments. The program functioned without a visual impairment specialist on staff during 1989-1991. However, only six children in the high intensity group were receiving intervention during this time, and all but two had received one year of intervention under supervision of the VI specialist.

Low intensity parent group treatment. Families in the low intensity control group were offered services in the form of group meetings which were held approximately 12 times per year for roughly one hour each. During 1987 and the majority of 1988, parent group meetings were conducted about twice monthly for approximately 9 months out of the year. Due to staff and funding changes, meetings in 1988-1989 were rescheduled to be held in two sessions, each session consisting of 6 weekly meetings. Although informal, there was always a specific topic for discussion, with readings assigned and time for questions and answers. Slides and tapes developed for use with Reach Out and Teach were also used. After an introductory meeting, appropriate professionals attended the meetings to discuss cognitive development, social skills, and temperament. Presentations focused on the effects of visual impairment on these various areas of development with general suggestions for compensation. General stimulation activities were suggested, but no individualized treatment plans or activities were provided.

After each presentation by a professional, parents were given time to ask specific questions and discuss issues of concern to them. These sessions also functioned as a support group, whereby parents with older children who were visually impaired offered support and information to the parents of younger children.

Treatment Verification

The following procedures were used to verify that treatment was implemented as intended.

__Collection of attendance data__. Parent and child participation in the individual sessions, as well as parent involvement in group meetings, were recorded according to length of session and staff involved. Non-attendance at regularly scheduled

Table 1.5

Treatment Verification Data for NO/VI Intensity Study: Report of Services Received Between Pretest and Reassessment #1

	Low Intensity			High Intensity			
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	SD	n	P Value
• Average length of intervention in months	12.7	(2.0)	17	12.3	(.5)	14	.46
• Total number of hours of parent meetings	3.4	(3.9)	16	---	---	14	.00
• Total number of hours of individual intervention	---	---	16	29.2	(8.8)	13	.00
• Intervenor's rating of parent involvement with intervention (range 0 to 45)	N/A	N/A	N/A	31.8	(6.1)	12	---
• Additional therapeutic services outside of assigned intervention							
% receiving Speech/Language therapy	6%			29%			.13
% receiving motor therapy	12%			29%			.29
% receiving daycare	53%			21%			.57
% receiving preschool	6%			31%			.13
• Evaluation of intervenors (range 0 to 30)	24.2			26.0			
• Parent satisfaction with services (range 0 to 4)	3.7	(.5)	7	3.7	(.5)	12	.996

sessions was also recorded according to the reason for non-attendance (e.g., child illness, vacation etc.). Attendance data are summarized in Table 1.5 for subjects following one year of intervention.

As can be seen, the amount of intervention received by each group was substantially different. In addition to the differences and number of hours of intervention received, the types of interventions were diverse. In the high-intensity group, each hour of intervention included individualized, specifically focused developmental activity; whereas in the low-intensity group, the hour of intervention consisted of general discussion around issues such as developmental milestones and facilitative strategies. Consequently, the study closely resembles a treatment versus no-treatment comparison.

Parent involvement in the home. Various strategies were used to measure parent report of time spent working with their child for those in the weekly intervention. However, accurate information was difficult to obtain, primarily due to the naturalistic learning and teaching approach of the program. Since the intervention in the high-intensity group stressed incidental learning activities to be integrated into the parent and child's daily routine, a discrete measure of time was not meaningful. Therefore, in lieu of a parent report of time, the intervenors rated the parents using a 9-item, 5-point Likert-type scale on their ability to integrate program suggestions at home. Examples of behaviors rated include the parent's ability to facilitate communication, encourage the child to use functional vision, and respond appropriately to the child's initiation. The mean score for the high intensity group reflected moderate to good ability of parents to integrate home activities (see Table 1.5). Since parents in the low intensity group were not expected to be involved in incidental teaching with their children, and no instructions were given to them as to how to be involved in such teaching, no measures were taken on this variable for the low intensity group.

Parent satisfaction. Given the important role that parents play in receiving services and providing intervention to their children, rating scales were developed to record parent's satisfaction with the services they were receiving based on their group assignments as well as the service provider's impression of the parents' levels of knowledge, attendance, and support. Both forms were completed at posttest time. All obtained information was kept confidential. As shown in Table 1.5, parents from both groups reported high satisfaction with the intervention they received.

Additional services. Given this experimental design, it was important to document any additional services that subjects in either group may have received. There were few, if any, other services designed specifically to treat children with visual impairments within the study's geographical area. However, there were other services available for children with developmental delays. Parents could have accessed motor and/or communicative disorders specialists, though this was expensive. The Children's Hospital also provided such therapies to families who were receiving public assistance. Although there were other infant programs, these did not specialize in serving children with visual impairments. Parents were not restricted from obtaining additional services, although there was little likelihood that parents would access them given the lack of availability and/or cost involved.

To collect information about additional services received, parents provided information via an interview with the assessment supervisor regarding any services that were obtained outside of the research program between Pretest and Posttest #1. Based on these data, it appeared that few subjects obtained a substantial amount of additional therapeutic services (see Table 1.5). Subjects in the high intensity group reported the receipt of significantly more preschool or daycare hours. In many cases, it was difficult to differentiate center-based daycare from a preschool program. If these services are combined, 60% of children in the low intensity group had no daycare/preschool, and 54% of the children in the high intensity group had no daycare/preschool; this makes the two groups highly comparable.

Additional services data were also collected between Reassessments #1 and #2. Many of the subjects turned three years of age after Reassessment #1, and no longer participated in the original birth-to-three intervention to which they were assigned. Additional services data are relevant only for subjects under three years of age for the purpose of determining any contamination of the two interventions in question.

Information on subjects given between Reassessment #1 and Reassessment #2 indicates that subjects in the high intensity group averaged slightly more additional services (see Table 1.6). It is worthwhile to note that the percentage differences represent few subjects. One high intensity subject received speech and language therapy. The differences in the daycare percentage (83% versus 67%) translates to

Table 1.6

Treatment Verification Data for LSU/VI Intensity Study: Receipt of Additional Services Outside of Assigned Intervention

Variable	Low Intensity $\bar{x}$	High Intensity $\bar{x}$	p Value
• Receipt of additional therapeutic services outside of assigned intervention at Reassessment #2			
% receiving Speech/Language therapy	0%	17%	.43
% receiving motor therapy	12%	17%	.81
% receiving daycare	25%	33%	.75
% receiving preschool	25%	50%	.42
• Reassessment #3			
% receiving Speech/Language therapy	0%	18%	.23
% receiving motor therapy	0%	9%	.48
• Reassessment #4			
% receiving Speech/Language therapy	0%	9%	.41
% receiving motor therapy	0%	9%	.42
• Reassessment #5			
% receiving Speech/Language therapy	0%	25%	.10
% receiving Physical/Occupational therapy	0%	8%	.49
% Educational therapy	0%	0%	.92
% parent tutoring	0%	0%	.92
% other services	0%	0%	.92

one more high intensity subject receiving daycare. There were three high intensity subjects and one low intensity subject involved in a preschool program. Again, it appears the overall differences between groups receiving additional services is not significant. Any small bias which exists is in favor of the high intensity group. At the time of Reassessments #3 and #4, the children had exited from the original early intervention services to which they were assigned (the subsequent placements are presented later in the Results section). In addition, data regarding any private therapy obtained by the families were collected; this is reported in Table 1.6. The results show that additional services were not obtained for any of the children in the low intensity group, and very few children from the high intensity group received any private therapy. This also holds true when the children completed reassessments #5. Therefore, the occurrence of additional therapies was not relevant in interpreting the child or family outcome data. Reassessment #6 additional services data will appear in the October, 1994 report.

Evaluations of intervenors. To assist in determining the quality of the intervention, ratings and rankings of the interventionists from both groups were conducted internally by program supervisors, as well as externally by the project site coordinator and an independent reviewer. The program supervisors provided information about the quality of the intervention via a 5-point rating scale in the areas of skills, problem solving, work habits, relationships, communication, and attitude. The average score for the intervenors in the high intensity group was 24.2, from a possible 30-point total. There was only one intervenor in the low intensity group, and she received a total score of 26 out of 30. All intervenors were then compared to professionals in similar positions and rated in either the top 10%, top 25%, top 75%, or bottom 25%. Four of the six intervenors in the high intensity intervention were rated in the top 10%, and the remaining two were rated in the top 25% of their peers. These results reflect a quality program as viewed by staff at the Human Development Center.

In addition to these measures of treatment verification, a formal on-site review was conducted in December, 1988, by the site coordinator. Based on observations of home intervention sessions, reviews of records, and interviews with staff, the program was providing the services as required for the study. A detailed report is available for more specific information.

Dr. Kay Alicyn Ferrell, a well-respected authority on serving young children with visual impairments, provided an independent assessment of the program's ability to meet the unique needs of this population. This independent evaluation occurred in October, 1989. Dr. Ferrell rated the program highly in the area of general assessment procedures, commending their use of child observations in the natural environment to supplement standardized testing. She noted, however, that attention to functional vision assessment and orientation and mobility assessment was lacking. She also suggested that more attention be given to the development of formal lesson plans and data collection, although the intervenor's records did provide good anecdotal information. IFSP development was rated as meeting all the criteria of a high-quality plan, and overall interaction with parents was viewed very positively. Dr. Ferrell stated that she was favorably impressed with the competencies of the staff in early childhood special education.

Dr. Ferrell noted that the intervenors had done an admirable job, and were serving visually impaired infants and their families far better than some agencies with trained specialists. The lack of staff with specialized training in visual impairment was the primary weakness of the intervention. However, Dr. Ferrell stressed that the presence of professionals certified in visual impairment alone does not necessarily equate to an appropriate early intervention program. Expertise in early childhood development and family intervention is of critical importance to an intervention such as this. The evaluation report in its entirety is available for review upon request.

Contextual Variables Which May Have Affected Results

Data were collected to determine the occurrence of other factors beyond the control of the experimenter which could potentially impact outcome. A comparison of the low- versus high-intensity groups on such factors follows.

__Child health data__. Parents completed a self-report questionnaire inquiry about their child's health over the past 12-month period. Quantitative information (e.g., the number of days hospitalized, number of ear infections, etc.) was gathered as well as a qualitative rating of the child's overall health compared to others of the same age. As shown in Table 1.7, no statistically significant differences were found in comparing the health of low versus high intensity children at Reassessments #1, #2, #3, or #4. Statistically significantly fewer children from the high-intensity group were hospitalized at reassessment #5; however, the general health ratings were similar. There were no statistically significant differences between groups on the health indices at Reassessment #6.

__Major life events__. As previously mentioned, the Family Inventory of Life Events and Changes (FILE) was administered as a core instrument to measure the occurrence of stressful life events. Although the FILE assesses the occurrence of positive as well as negative life events, both are viewed as causing an increase in stress. Therefore, any differences in the amount of life events between groups may influence the study results. As shown in Table 1.7, no statistically significant differences were found between groups at Reassessment #1 or #2, and both groups received mean scores in the average percentile range. At Reassessment #2, however, the mean score for the high intensity group was slightly higher (although non-significant); this was found to be due to one parent who reported the occurrence of many stressful life events which skewed the means. The FILE was not collected at Reassessments #3 or #4 due to negative comments from some parents regarding its intrusiveness. At reassessment #5 the Holmes Rahe Social Readjustment Rating Scale was used to determine the occurrence of major life events which could potentially impact child and family outcome variables. No statistically significant differences were found on these variables at reassessment #5 or #6. Based on these analyses, there did not appear to be any measured extraneous factors which warranted consideration in the analysis.

Table 1.7

Contextual Variables as Measured by the Family Inventory of Life Events and Changes at Reassessments #1, #2, #3, #4, #5, and #6

	Low Intensity				High Intensity					
	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	p Value	ES
Reassessment #1										
FILE	7.2	(4.5)	55	17	10.1	(9.0)	40	13	.54	-.42
% no hospital	77				69				.67	.15
% no infections	100				100				1.00	.00
General Health'	1.9	(.5)		17	2.0	(.7)		13	.59	.20
Reassessment #2										
FILE	6.8	(3.1)	69	14	10.7	(8.8)	40	12	.13	-1.26
% no hospital	73				92				.33	.36
% no infections	93				100				.68	.15
General Health'	2.1	(.5)		15	2.3	(.5)		12	.31	.40
Reassessment #3										
% no hospital	92			13	100			10	.70	.15
% no infections	85			13	100			10	.42	.32
General Health'	2.2	(.4)		13	2.2	(.4)		10	1.00	.00
Reassessment #4										
% no hospital	80			15	75			12	.77	-.11
% no infections	80			15	92			12	.42	.23
General Health'	2.2	(.6)		15	2.0	(.6)		12	.38	-.33
Reassessment #5										
% no hospital	81			16	92			13	.09	.22
% no infections	94			16	92			13	.77	-.07
General Health	2.1	(.6)		15	2.1	(.5)		13	.56	.00
Holmes & Rahe Total Events Score	99.1	(87.2)		16	155.5	(136.6)		13	.24	.65
Primary Negative Events Score	32	40.8		16	32.5	(51.4)		13	.21	.01
Reassessment #6										
% no hospital	86			14	92			12	.36	-.12
% no infections	86			14	83			12	.75	.06
General Health	2.0	(.6)		14	2.3	(.6)		12	.20	.20
Holmes & Rahe										
Total Events	129.2	(106.1)		13	150.5	(109.4)		13	.63	.20
Negative Events	52.1	(53.0)		13	26.5	(61.8)		13	.60	.48

'1 = Worse than others, 2 = Same as others, 3 = Better than others

Cost of Alternative Interventions

Program costs were calculated using the ingredients approach. The ingredients approach is a systematic, well-tested procedure for identifying all of the social costs for implementing alternative programs, including costs that are often omitted from cost analysis such as contributed (in-kind) and shared resources. In this approach, an exhaustive list of resources used by each alternative is developed, and the ingredients are costed according to observed market values (e.g., salaries) or opportunity cost (e.g., parent time). An opportunity cost is the value of a resource in its next best alternative use. For example, parents participating in intervention activities could have been engaged in other productive activities; these foregone activities represent a cost to parents. Since we have no information about any one individual's opportunity costs, we estimated the value of an individual's time based on national data. The amount of parent or non-parent volunteer time required for the study was assigned the pecuniary value of $9 per hour based on the "median usual weekly earnings for full-time work" plus benefits (U.S. Department of Labor, Bureau of Labor Statistics, 1989). As shown in Table 1.8, each alternative used varying amounts of the indicated resources. The following sections describe the resources and costs used for the weekly home visit program and the parent group meetings.

Analysis of the cost data for the New Orleans VI project reflects the per-child costs for the individualized, weekly home-visit intervention versus the low intensity parent group intervention. These data were collected in June of 1988 and are adjusted for inflation to 1990 dollars. Since there had not been any major changes in the interventions, cost data were not collected each subsequent year.

Table 1.8

Cost per Child for NO-VI Site (1990 Dollars)

Resources	High Intensity (n=15)	Low Intensity (n=15)
Agency Resources		
Direct services	$3,942	$ 269
Administration		
program	1,620	
175		
university	702	60
Occupancy	321	9
Equipment	125	9
Transportation	108	0
Materials/supplies	79	20
Telephone	75	1
Sub Total	$6,272	$ 543
Contributed Resources		
Direct services	0	16
Parent time	234	232
Parent transportation	428	115
Sub Total	$ 662	$ 363
Total	**$6,934**	**$ 906**

* Totals may not add up due to rounding errors.

Cost of high intensity, weekly home-visit intervention. Salaries and benefits for direct service and administrative personnel were determined according to their FTE devoted to this aspect of the project. Direct service personnel included two teachers, an occupational therapist, a speech therapist, a physical therapist, a social worker, a developmental pediatrician, and a temporary home-based teacher hired for three months on a consulting basis. Administrative personnel included the program director, the principal, and a secretary. University administration was calculated using the LSU indirect rate of 12.6% for general, departmental, and sponsored projects administration. Parent time was required for participation in home visits, special sessions with the therapists, and for programming assessments. The opportunity cost of parent time ($9/hour) was applied to the average time (23.2 hours) each parent spent in the home-based visits during 1987-88. However, the actual value of parent contributions is probably much higher in this program than it appears since the majority of parent contribution was involved via incidental teaching strategies that are difficult to measure quantitatively. Thus, the actual estimation of value of parent time is most likely an underestimate of what the parents actually contributed.

Occupancy charges, including space, maintenance, utilities, and insurance costs, are based on office leasing costs in the area. Nine dollars per square foot was applied to the 478 square feet used by the program (also pro-rated according to FTE). Annual equipment cost was determined by taking inventory of all instructional materials, office furniture, and equipment. Market replacement values were then applied to each item, costs were annualized accounting for interest and depreciation, and prorated according to the percent FTE worked on the project. Staff travel was based on actual mileage (.21 per mile) for home visits. Parents were reimbursed for travel to the center for weekly intervention services. For parents who were not reimbursed, information was collected via telephone interview on the number of trips made to the center, round-trip distance, and approximate time spent in travel. Parent transportation costs were then calculated based on $.21 per mile and the opportunity cost of parent time ($9/hour) spent in travel. The cost of materials, supplies, and telephone charges were assessed based on actual usage of these items.

Cost of low intensity, parent group meetings. Direct service costs for the low intensity parent group meetings involved compensation for the group leader on a contractual basis. Various professionals assisted the group leader in addressing specific topics on a volunteer basis. The opportunity cost of their time was determined at $25 per hour for 9 hours. Program administrative cost included a small portion of the site liaison's FTE. University administrative cost was based on the indirect rate as explained above. Parent costs included time spent in the group meetings (based on average attendance), as well as time and expenses associated with travel to the meetings (parent travel information was obtained for this group also by telephone interview). Occupancy cost, calculated at $9 per square foot, (for 47 square feet, pro-rated according to usage by the program) was calculated for the group meeting room at the LSU Eye Center and the site liaison's office. Equipment costs for the group meetings include instructional/curricular materials (Reach Out and Teach) and office equipment and furniture which was valued, annualized, and pro-rated according to FTE. Finally, telephone and materials and supplies costs were assessed based on annual actual usage.

Data Collection

Data on children and their families were collected using instruments selected to yield descriptive information (i.e., demographics) as well as assess treatment effects. A description of diagnostician requirements is described below, followed by descriptions of the pretest and reassessment instruments for this study (refer to Tables 1.9 and 1.10 for summary and descriptions of measures).

Recruitment, training, and monitoring of diagnosticians. All testers recruited for the study successfully completed the certification process required for administration of the Battelle Developmental Inventory. The training involved approximately 4 hours of independent study, 8 hours of group training, and a minimum of 3 practice administrations with 85% interrater agreement required. From the beginning of the study in 1987, through 1989, testers were recruited through the Human Development Center (HDC) at Louisiana State University Medical Center. As of January, 1990, testers were recruited from the Special Education Department at the University of New Orleans. All of the diagnosticians had bachelor's or master's degrees and extensive experience assessing infants and children with disabilities, including visual impairments. All the testers were naive to the subject assignment. Shadowscoring was conducted on 10% of the BDI administrations, averaging 93% interrater agreement. Assessment supervisors were recruited from the New Orleans area to coordinate the schedule of the testing, review the data for completeness, and conduct tester reliability checks.

Table 1.9

Schedule of Administration and Tests Administered at Pretest and Reassessment 1-6 for New Orleans Visual Impairment Study

	Pretest	Reass. #1	Reass. #2	Reass. #3	Reass. #4	Reass. #5	Reass. #6	Reass. #7
CHILD MEASURES								
Battelle Developmental Inventory	X	X	X	X	X	X (motor)		
Play Assessment Scale Videotaped Scenario of Exploration/Play			X					
Early Intervention Developmental Profile		X						
Vineland Adaptive Behavior Scales			X	X	X	X	X	X
Carolina Record of Individual Behavior		X						
Boehm Test of Basic Concepts					X			
Test of Language Development, Primary, 2nd Ed.						X	X	
McCarthy Scales of Children's Abilities						X	X	
Social Skill Rating System				X	X	X	X	X
Forced-Choice Preferential Looking Technique	X	X						
Hill Performance Scale							X	X
WISC III								X
FAMILY MEASURES								
Parenting Stress Index	X	X	X	X	X	X	X	X
Family Support Scale	X	X	X	X	X	X	X	X
Family Resource Scale	X	X	X	X	X	X	X	X
Family Inventory of Life Events and Changes	X	X	X					
Family Adaptation and Cohesion Scales	X	X	X	X	X			
Videotaped Scenario of Parent/Child Interaction	X	X	X	X				
Holmes-Rahe Schedule of Recent Events						X	X	X
Parent Self-Awareness Scale						X	X	X
Family Functioning Style Survey								X

Table 1.10

Description of Tests Administered for New Orleans Visual Impairment Study

MEASURES	DESCRIPTION
Battelle Developmental Inventory (BDI) (Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984)	A norm-referenced test of developmental functioning completed through child administration and parent interview. Assesses personal/social, adaptive, motor, communication, and cognitive skills, and provides a total score.
The Boehm Test of Basic Concepts--Form A (Boehm, 1971) The Tactile Analog (Caton, 1976)	This instrument is designed to measure children's mastery of concepts considered necessary in kindergarten through second grade. The BTBC consists of a series of 50 picture items and could easily be used with many low vision children. The TTBC is composed of 50 plastic sheets on which 50 items of the BTBC are presented in raised outline drawings. Internal consistency and content validity are reported to be sound.
The Vineland Adaptive Behavior Scales--Survey Edition (Sparrow, Balla, and Cicchetti (1984)	This version provides a general assessment of adaptive behavior, covering the domains of communication, daily living skills, socialization, and motor skills. It is administered to a parent or caregiver in a semistructured interview format. It is appropriate for use with persons ages birth to adult. Standard scores and age equivalents are obtainable. Norms for special populations (i.e., visually impaired) are also provided. Interrater reliabilities, internal consistencies, and concurrent validity data strongly support its use.
Videotaped Scenario of Exploration/Play (E.I.R.I.)	A standard protocol was developed by EIRI to assess exploration and independent play behaviors in children with visual impairments. Based on a review of the literature, standard toys were selected. The protocol lends itself to use with various systems (i.e., Fewell, Belsky). This assessment provides information on the child's use of senses and an estimate of cognitive development in a nonthreatening, child-directed manner. Play Assessment Scale (Fewell, 86).
Forced-Choice Preferential Looking Technique	This is a newly-developed acuity test for young children 1 to 36 months, developmentally. It has been proven useful with difficult-to-test children, and those who are unresponsive to traditional acuity measures. During the testing, the child is shown a stimulus display containing a black-and-white grating on one side and a homogenous gray target on the other. Acuity is determined according to the stripe width to which the child fixates. It has been shown to successfully estimate acuity in 95% of study sample.
The Carolina Record of Individual Behavior (Simeonsson, 1981)	This instrument is a rating of variables related to the child's interaction with the environment, a key focus of the high intensity intervention. Ratings are based on the diagnostician's clinical impressions when administering the EIDP. Sound test-retest reliabilities are reported as well as some degree of construct validity.
The Early Intervention Developmental Profile (Brown et al., 1981)	This is a criterion and age-referenced instrument that assesses all major areas of development with an emphasis on sensorimotor intellectual markers. It has 299 items broken down into small age ranges. The manual reports strong concurrent validity with other standardized measures as well as strong interrater and test-retest reliabilities.
Videotaped Scenario of Parent-Child Interaction	A standardized protocol was developed by EIRI which would lend itself to various methods of evading parent-child interaction. A 20-minute routine included free play and a structured activity (storytelling), as well as parent-child separation and reunion.
McCarthy Scales of Children's Abilities	A test designed to determine the intellectual development of children. Only the verbal scale was administered because it does not rely on visual stimulation.
Test of Language Development Primary--II	A test designed to identify language skills used by children and how they compare to their peers. This test helps identify any problems in language proficiency; determining specific strengths and weaknesses in language skills; to keep track of progress the children make.
Social Skills Rating System	This parent survey was used to assess social skills used in the home and community. It is based on parent self-report.

(continued)

Table 1.10 (continued)

Description of Tests Administered for New Orleans Visual Impairment Study

MEASURES	DESCRIPTION
The Hill Performance Scale (Hill, 1981)	Assesses specific positional concepts with children with visual impairments ages 6-10 years. Concepts include position of relationships of body parts, moving body parts in relation to other body parts and objects, and object-to-object relationships.
Wechsler Intelligence Scale For Children, III (Wechsler, D., 1991)	A standardized, norm-referenced test designed to measure intellectual development in children. Only the verbal scale was administered because it does not rely on visual stimulation.
FAMILY MEASURES	
Parent Stress Index (PSI) (Abidin, 1983)	Assesses parent perceptions of stress on the parent-child system. The two main domains are child-related factors and parent factors.
Family Support Scale (FSS) (Dunst, Jenkins, & Trivette, 1984)	Assesses the availability of sources of support as well as the degree to which different sources of support provided are perceived as helpful to families rearing young children.
Family Resource Scale (FRS) (Dunst & Leet, 1985)	Assesses the extent to which different types of resources are perceived as adequate in households with young children. Factors include: General Resources, Time Availability, Physical Resources, and External Support.
Parent Self-Awareness Scale	A self-report measure containing 43 events associated with stress requiring the respondent to mark those events which occurred within the past year. A total life stress score, as well as a score for negative events, are calculated.
Family Inventory of Life Events and Changes (FILE) (McCubbin, Patterson, & Wilson, 1983)	Assesses life events and changes experienced by a family unit during the past 12 months. The specific areas of potential strain covered by the scale include: intra-family, martial, pregnancy and childbearing, finance and business, work-family transitions, illness and family "care," losses, transitions "in and out," and legal.
Family Adaptation and Cohesion Evaluation Scale - III (FACES) (Olson, Portner, & Lavee, 1985)	Provides a general picture of family functioning by assessing the family's level of adaptability and cohesion. Family cohesion assesses degree of separation or connection of family members to the family. Adaptability assesses the extent to which the family system is flexible and able to change in various situations. The scale also has a perceived as well as ideal form that provides an indication of the extent to which current family functioning is consistent with the family's expectations for ideal family functioning.
Assessment of Mother/Child Interaction	Assesses the quantity and quality of maternal interaction behaviors. A videotaped standardized protocol is followed, which is then assessed using multiple rating systems.
Family Functioning Style Scale (FFSS: Deal, & Trivette, 1988)	A 26-item scale that assesses the extent to which the respondent (typically mother) belives their family is characterized by different strengths and capabilities.

Assessment supervisors had either a masters or a Ph.D. degree with expertise in diagnostic evaluation.

Pretest. After children were identified and assigned to groups based on their visual acuity and screening results, a pretest battery consisting of the Battelle Developmental Inventory (BDI), Parenting Stress Inventory (PSI), Family Support Scale (FSS), Family Resource Scale (FRS), Family Inventory of Life Events and Changes

(FILE), and the Family Adaptability and Cohesion Evaluation Scales (FACES III), were administered. (Specific psychometric information regarding these measures can be found in the EIEI 1986-87 annual report.) Demographic information was also obtained via interview with the parent. These measures were considered as potential covariates in the Reassessment analyses and were used to investigate whether certain types of families or certain types of children benefit more from intervention.

The BDI was administered by a trained diagnostician who was unaware of the child's group assignment. Testing occurred at the Human Development Center in New Orleans, ensuring that the testing setting was the same for all subjects.

The family measures were completed by the parent attending the testing session following the administration of the BDI. Married parents and those with spouse equivalents were also given a copy of the FSS to take home for their partner to complete. To encourage and reinforce parent participation in the assessment process, parents were paid a monetary incentive of $20 for completing the pretest battery. The diagnostician scored the BDI and completed a testing report. The diagnostician did not score the family measures. All data were then transmitted to the assessment supervisor. The assessment supervisor maintained copies of all of the protocols for the on-site records and submitted the original protocols via certified mail to the EIRI site coordinator who supervised checking of the accuracy and completeness of the protocols, scoring of the family measures, and computer data entry.

Reassessment #1. Reassessment measures were collected after children were in the program for 12 months. These included the Battelle Developmental Inventory and the family measures previously described. In addition, the Early Intervention Developmental Profile (EIDP) (Brown et al., 1981) the Carolina Record of Individual Behavior (CRIB) (Simeonsson, 1981), Assessment of Preferential Looking, and videotaped assessment of parent-child interaction were collected one year from the date of pretest. Parents were again paid to compensate them for their efforts (refer to Table 1.10 for a description of these measures).

The EIDP was administered in conjunction with the BDI, with identical items being scored based on the child's BDI performance and unique items being administered following the BDI administration. A separate diagnostician, also naive to subject assignment, administered the EIDP. The Carolina Record of Individual Behavior (CRIB) was completed on each child based on the BDI diagnostician's clinical impressions when administering the EIDP.

Forced Preferential Looking (Teller, Morse, Boston, & Regal, 1974) was conducted at both pre- and reassessment #1 through the LSU Eye Center. The pretest preferential looking test was used to stratify according to acuity for group assignment. Preferential looking was also conducted as a reassessment measure in order to monitor any changes in vision which may impact test results. As the children grew older, traditional acuity tests (e.g., Lighthouse cards) were used.

Videotaped assessment of parent-child interaction was used to measure the effects of intervention on parent-child relationships. This was considered to be an important outcome given the dramatic differences in the two treatments being compared. This information can potentially provide further insight into the effects of a visual impairment on parent-child relationships.

Three coding systems were piloted to code the tapes, each using a slightly different approach to analysis. The Parent/Caregiver Involvement Scale (Farran, Kasari, Comfort, & Jay, 1986), rates maternal behavioral descriptors on a 5-point scale across three dimensions: amount, quality, and appropriateness. Global ratings of (1) availability of parent to child, (2) general acceptance and approval manifested by parent, (3) general atmosphere, (4) enjoyment, and (5) provision of learning environment. All of the Reassessment #1 tapes have been coded using this system. The Parent-Child Behavioral Observation System (Marfo, 1989) examines behavior as a dynamic process, measuring both child and parent behaviors and how they interact. Eighty percent of the tapes have been coded by Marfo. The Parental Behavior Rating Scale (Mahoney, 1988) rates 12 parental behaviors (warmth, expressiveness, enjoyment, acceptance, sensitivity to child's interest, responsivity, effectiveness, directiveness, achievement, orientation, paces, inventiveness, and verbal praise) which are divided into three factors of (1) affective relationship with child, (2) orientation responsivity to child, and (3) performance orientation. Ratings are based on a 5-point Likert-type scale.

These measures provide information which is useful in establishing the comparability of the two intervention groups as well as providing information to investigate whether certain types of families or children benefit more from the intervention procedures.

Reassessment #2. The measures administered two years from the date of pretest (Reassessment #2) include the BDI and the previously described family measures. Complementary measures include the assessment of preferential looking and two videotaped assessment procedures. One of these was the previously-described videotaped assessment of parent-child interaction. In addition to assessing group differences, this measure was repeated with the intention of providing insight into the impact of a visual impairment on later parent-child interactions.

The other videotaped assessment was a standardized procedure for assessing exploration and play. Both exploration (the skills used to obtain information about novelties in the environment) and play (involving the application of information obtained through exploration) are outcome measures that are not assessed through traditional assessments, and yet are behaviors that have been closely related to cognition, language, and social development. Learning through exploration and play were strategies emphasized by the high-intensity, weekly intervention program. The Play Assessment Scale (Fewell, 1986) was used to analyze the exploration/free play videotaped scenarios.

By the time of Reassessment 2, many families had relocated out of the original catchment area, making it difficult for families to come to a central testing area. Therefore, some families were tested in their homes. However, testers made every effort to ensure that there was a structured atmosphere similar to that of the center-based testing atmosphere. It is also worth noting that parents reported preferring the home setting due to their children feeling more comfortable with the familiar environment.

Reassessment #3. The reassessment measures used three years after pretest serve to measure the long-term effects of the intervention. These measures include the BDI and the previously described family measures with the exclusion of the Family Inventory Life Events and Change (FILE). Additionally, the Vineland Adaptive Behavior Scales (Sparrow et al., 1984) were selected to obtain a more detailed estimate of the child's ability to function independently. The items on the Vineland tend to be less vision-oriented; in fact, norms for children with visual impairments are provided. Educational placement and support services were documented to determine any differences in degree of special services due to the group assignment. Also (according to Table 1.9), a videotaped scenario of parent/child interaction (as previously described) was given.

Reassessment #4. The reassessment measures used at four years from pretest include the BDI as well as the Vineland Adaptive Behavior Scales. In addition, the Boehm Test of Basic Concepts (Boehm, 1971) was used to assess concepts requisite for school success. The Boehm stimulus materials lend themselves to enlargement for low vision children; there is also a tactile analogue to the Boehm which is appropriate for totally blind children. The Social Skills Rating System (Gresham & Elliott, 1990) was used to assess the social and school survival skills of the child; both the teacher- and parent-report versions were used. The Parenting Stress Index, the Family Resource Scale, the Family Support Scale, and the Family Adaptability and Cohesion Evaluation Scales III are also part of the Reassessment #4 battery.

Reassessment #5. The Vineland Adaptive Behavior Scales, the Social Skills Rating System, and the motor domain of the BDI were administered. Since the majority of the children functioned above the developmental limits of the other BDI domains, portions of the McCarthy Scales of Children's Abilities and the Test of Language Development--Primary, second edition were used to obtain an estimate of cognition and language development. Only those subscales which did not require vision were used. The Parenting Stress Index--Short Form, the Family Resource Scale, and the Family Support Scale continued to be used as family functioning measures. The Parent Self-Awareness Scale (Snyder, Weeldreyer, Dunst, & Cooper, 1986) was selected to consider the parent's sense of empowerment in dealing with the child's educational/intervention needs. The Scale of Recent Events (Holmes & Rahe, 1967) was used to identify the occurrence of life events which could impact family functioning. Reassessment #5 data have been collected on roughly half of the subjects due to staggered enrollment; these results will be available by October, 1993.

Reassessment #6. Child outcome measures consisted of the verbal, nonvisual subtests of the McCarthy Scales of Children's Abilities and Test of Language Development, Primary, second edition. The Hill Performance Scale was administered to assess the child's applied motor skills. The test was specifically designed for use with children with visual impairments. The Vineland Adaptive Behavior Scale and the Social Skills Rating System were completed via parent self report. Family measures were consistent with those collected at Reassessment #5.

Reassessment #7. As the children reached chronological ages of 7-9 years, intellectual development was measured using the Weschler Intelligence Scale for Children, third edition. Functional motor skills continued to be measured with the Hill Performance Scale, Social Skills by the SSRS, and Adaptive Behavior by the Vineland. The Family Functioning Style Scale was added to tap family strengths related to their functioning as a family unit.

Results and Discussion

The following section presents results of the study with respect to comparability of the groups on pretest measures, and the findings regarding the effects of alternative forms of intervention on measures of child and family functioning. To date, the results only pertain to the findings based on Reassessments 1 through 6. The Reassessment #5 data will be completed and fully analyzed by the October, 1994 report. Reassessment #6 data reflect approximately 80% of the total data cohort.

Comparability of Groups on Pretest Measures

Table 1.11 presents comparability of groups for all active subjects. (Scores for the FILE were reported here for the sake of showing comparability at pretest time. However, it was not viewed as an outcome measure.) BDI gross motor and motor

Table 1.11

Comparability of Groups on Pretest Measures for NO/VI Intensity Study

	Low Intensity				High Intensity					
	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	p Value	ES^
• Age in months at pretest	14.5	(10.0)		17	13.1	(12.5)		14	.75	-.14
• **Battelle Developmental Inventory (BDI)+**										
Personal Social	39.3	(22.2)		17	32.7	(24.1)		14	.44	-.30
Adaptive Behavior	29.5	(18.5)		17	22.8	(17.2)		14	.31	-.36
Gross Motor	30.5	(18.8)		17	18.3	(14.4)		14	.06	-.65
Fine Motor	13.7	(9.8)		17	10.0	(9.1)		14	.29	-.38
Motor Total	44.2	(27.9)		17	28.3	(23.3)		14	.10	-.57
Communication	24.0	(14.9)		17	18.5	(15.9)		14	.33	-.37
Cognitive	16.1	(11.8)		17	11.4	(8.9)		14	.23	-.40
TOTAL	153.1	(92.9)		17	113.6	(87.3)		14	.24	-.43
• **Parenting Stress Index (PSI) Percentile Rank****										
Child Related (range 47 to 235)	102.4	(22.5)	60	17	100.6	(16.6)	57	14	.81	+.08
Other Related (range 54 to 270)	120.9	(17.5)	50	17	114.9	(17.8)	40	14	.36	+.34
TOTAL (range 101 to 505)	223.3	(34.2)	53	17	216.1	(29.4)	43	14	.54	+.21
• **Family Adaptation and Cohesion Evaluation Scales (FACES)**										
Adaptation	23.8	(6.0)		17	23.3	(5.6)		14	.82	-.08
Cohesion	39.9	(5.7)		17	40.1	(6.5)		14	.95	.04
• **Family Resource Scale (FRS)****	131.6	(10.2)	74	17	117.3	(18.4)	48	14	.02	-1.40
• **Family Index of Life Events (FILE)****	7.9	(5.3)	55	17	10.4	(5.9)	40	14	.24	-.47
• **Family Support Scale (FSS)****	28.3	(11.5)	52	17	28.6	(10.4)	53	14	.93	-.03

^ Effect Size (ES) is defined here as difference between groups (high intensity minus low intensity) on $\bar{x}$ scores, divided by the standard deviation of the Low Intensity Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of effect size).

+ Statistical analyses for BDI scores were conducted using raw scores for each of the scales.

@ A low raw score and/or a low percentile score indicates lower stress level.

Statistical analysis and effect size (ES) estimates for PSI and FILE were based on raw scores where low raw scores and positive ES are most desirable.

& Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

% No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on 645 children with disabilities collected as a part of the Longitudinal Studies.

' A low raw score and/or a high percentile score indicates lower stress level, and a positive effect size is more desirable.

total pretest scores are statistically significantly higher for the low intensity group (p = .06 and .10, respectively). In comparing the scores on the family measures between groups, the mean FRS score was significantly lower (p = .02) for the high intensity families; therefore, the FRS was considered as a covariate in the analyses of Reassessment data.

Given the differences in BDI gross motor and FRS scores among the low versus high intensity group, these variables were used as covariates in the Reassessment analyses.

Effects of Alternative Forms of Intervention on Measures of Child Functioning

Data are presented for children who were tested after one year of intervention, followed by data on children who were reassessed two, three, and four years from the date of pretest. All pretest and demographic variables were considered as potential covariates. The final selection of covariates depended on a judgment of which variable or set of variables could be used to maximize the correlation or multiple correlation with the outcome variable in question and still include those demographic or pretest variables for which there are the largest pretreatment differences. In each analysis, the specific covariates used are indicated in the table.

Although sample sizes for this study are as large or larger than previous early intervention studies with these types of children, the statistical power of the analysis is still a concern. By setting the alpha level for all tests of statistical significance at $p \leq .10$, and by using analysis of covariance procedures, the statistical power of the analyses was substantially increased. According to Hopkins (1973) and Cohen (1977) in those cases where a covariate or set of covariates could be found which correlated with the dependent variable in question (which was almost the case in these analyses), and with alpha set at $p \leq .10$, the statistical power was approximately 87% for finding moderate sized differences (defined by Cohen as differences of a half a standard deviation) when analyzing child outcome variables.

Results of Reassessment #1. Table 1.12 summarizes the reassessment data for both low and high intensity subjects who have received the prescribed intervention for one year. Analyses of covariance were conducted for the BDI raw scores using the gross motor raw score and the Family Resource Scales, as these variables were different for the two treatment groups at pretest time and were highly correlated with outcome variables. Chronological age at pretest was also used as a covariate due to the high degree of variability and its correlation with the outcome measures.

Analysis of the BDI Reassessment data show that the adjusted means for BDI for gross motor scores were statistically significantly different in favor of the low intensity group ($p = .02$). Adaptive, fine motor, communication, and cognitive domains, as well as BDI total scores, were higher, but not statistically significant (at the $p \leq .10$ level) for the high intensity group. Scores for the Early Intervention Developmental Profile, a criterion-referenced measure, are also reported in Table 1.12, using the Battelle gross motor raw score, the FRS, and chronological age at pretest as covariates. The low intensity group generally scored higher on all domains, except for self care with the gross motor subdomain reflecting statistical significance. The average effect size for these two developmental measures was -.05. Scores for the Carolina Record of Individual Behavior are reported for selected domains based on the ability to provide unique information as well as those most pertinent to the study. Scores for social orientation (reflects the child's responsiveness to persons in the environment), participation (describes the child's participation with the examiner), attention span (degree of persistence in attending to object, person, or activity), responsiveness to caretaker (degree of contact through eye contact, vocalizations, and/or touch), and negative affect (crying, avoidance, clinging) revealed no significant differences between groups. The high intensity group scored significantly better ($p \leq .05$) in the areas of exploration of

Table 1.12

Reassessment #1 Measures of Child Functioning for Alternative Intervention Groups for NO/VI Study

		Low Intensity				High Intensity						
Variable	Covariates	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	ANCOVA F	p Value	ES
• Average length of intervention in months		12.7	(2.0)		17	12.3	(.5)		14	.46	-.20	
• Age in months at Reassessment		27.9	(9.9)		17	26.1	(13.4)		14	.67	-.18	
• **Battelle Developmental Inventory (BDI)**	1,2,3											
Personal-Social		80.4	(30.7)	71.3	17	62.6	(27.9)	71.8	14	.00	.94	+.02
Adaptive Behavior		51.3	(15.2)	46.5	17	44.0	(16.0)	48.8	14	.35	.56	+.15
Fine Motor		26.9	(11.4)	23.9	17	21.1	(9.0)	24.1	14	.00	.95	+.02
Gross Motor		48.8	(10.9)	45.5	17	35.2	(11.7)	38.5	14	5.80	.02	-.64
Communication		42.6	(17.5)	36.7	17	34.5	(14.5)	39.5	14	.19	.67	+.16
Cognitive		30.0	(13.9)	26.2	17	25.4	(13.9)	29.2	14	.54	.47	+.22
TOTAL		279.9	(94.6)	251.0	17	222.9	(89.0)	251.8	14	.00	.97	.00
• **EIDP**	1,2,3											
Gross Motor		69.6	(18.0)	65.0	17	53.8	(13.3)	58.4	14	3.18	.09	-.37
Fine Motor		36.4	(18.1)	32.5	17	27.8	(12.2)	31.7	14	.03	.86	-.04
Self-Care		38.8	(13.7)	34.9	17	32.8	(12.0)	36.7	13	.34	.57	+.13
Cognitive		37.2	(16.6)	33.0	17	25.8	(11.0)	30.0	14	.61	.44	-.18
Social		37.6	(13.2)	33.5	16	29.5	(11.5)	33.6	14	.00	.98	.00
Language		40.2	(15.6)	34.6	16	26.7	(14.0)	32.3	14	.63	.44	-.15
• **CRIB**	1,2,3											
Social Orientation (range 0-9)		8.1	(1.3)	7.8	17	7.6	(1.6)	7.9	14	.03	.86	+.08
Participation (range 0-9)		6.4	(2.0)	6.0	17	6.1	(2.1)	6.5	14	.32	.58	+.25
Reactivity (range 0-5)		5.3	(.9)	5.5	17	4.9	(.8)	4.7	14	5.20	.03	+.94
Attention (range 0-5)		5.6	(1.0)	5.6	17	5.7	(1.1)	5.8	14	.26	.62	-.20
Responsiveness (range 0-5)		5.1	(.4)	5.0	17	5.1	(.7)	5.1	14	.23	.63	-.23
Negative Affect (range 0-16)		4.4	(3.3)	4.5	17	4.4	(3.9)	4.4	14	.01	.93	+.03
Positive Affect (range 0-8)		4.4	(2.0)	4.3	17	2.7	(1.1)	2.8	14	4.90	.04	-.75
Exploration (range 0-12)		1.3	(.5)	1.3	17	1.8	(.8)	1.8	14	4.34	.05	+.94

Effect size (ES) is defined here as the difference between the groups (high minus low) on the $\bar{x}$ scores, divided by the standard deviation of the Basic Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of effect size).

Statistical analysis for BDI scores was based on raw score data.

Analyses for the Early Intervention Developmental Profile are based on raw scores for the number of correct responses.

Scores are based on a 9-point range with 1 as the most basic level and 9 the most advanced; therefore, high scores are best.

Scores are based on the "ideal" score reported in the manual. A score of "0" is best, and positive ESs indicate that the high intensity intervention group scored better.

Covariates: 1 = BDI Gross Motor Raw; 2 = Family Resource Scale Raw; 3 = Chronological Age at Pretest objects using the senses (i.e., tactile via hands and mouth, olfactory) and reactivity (the ease with which the child is stimulated). The score for positive affect (laughing/smiling) was statistically significant (p = .04) in favor of the low intensity group. The mean effect size for the CRIB subscales was +.13.

Subgroup analysis. A subgroup analysis was performed on Reassessment #1 data applying a two-way analysis of variance by intervention group and by severity of vision loss (acuity worse than 20/800 versus acuity better than 20/800), using Battelle raw scores as dependent variables. No statistically significant interactions were found between intervention and degree of vision loss. However, as would be expected, Battelle scores were influenced by degree of vision loss alone, with children whose acuity was worse than 20/800 receiving lower scores.

The effects of socioeconomic status on degree of child progress was also analyzed, applying a two-way analysis of variance by intervention and by income [income greater than $13,000 (the median income) versus income less than $13,000]. Results reflect a trend toward the high intensity group having a greater impact on BDI scores for families with incomes more than $13,000 compared to families with incomes less than $13,000; however, only one of the five domains (adaptive) reached a level of significance ($p \leq .03$).

Results of Reassessment #2. Data were obtained on 28 of the 31 active subjects. As mentioned in the treatment verification section, the degree of intervention has varied for subjects between reassessments #1 and #2. Of the 13 subjects assigned to the high intensity intervention, 7 subjects continued to receive the prescribed intervention and 6 graduated from the program upon reaching 3 years of age. Of the 15 children assigned to the low intensity intervention, 8 continued to participate in the original assigned intervention, although their attendance at the group meetings was negligible. Seven children graduated from the program upon reaching three years of age. A summary of the educational services obtained for those children over 3 years of age is presented in Table 1.13. As portrayed in the table, both groups have been receiving a wide range of services. However, this appears to be balanced across groups.

Table 1.13
Summary of Educational Services at Reassessment #2 for Subjects Who Graduated from Original Assigned Intervention in the New Orleans VI Study

	Low Intensity (n = 7)	High Intensity (n = 8)
Regular Preschool/No Special Services	4	3
Integrated Special Education Services	3	4
Self-Contained Special Education Services	2	1
Other	3	1

Given the various types of interventions present within the low and high intensity intervention groups due to the exiting of subjects from the original intervention upon reaching age 3 years, it is difficult to draw a conclusion regarding two years of consistent intervention. Rather, the data in Table 1.14 reflect the long-term effects of one year of the prescribed interventions.

Table 1.14

Reassessment #2 Measures of Child Functioning for Alternative Intervention Groups for NO/VI Study

		Low Intensity				High Intensity						
Variable	Covariates*	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	ANCOVA F	P Value	ES
• **Average time between Pretest and Reassessment #2**		26.8	(2.1)		15	28.5	(3.8)		13	3.20	.15	.80
• **Age in months at Reassessment**		42.3	(9.4)		15	42.2	(12.3)		13	1.70	1.00	-.01
• **Battelle Developmental' Inventory F (BDI)**												
Personal/Social	1,2	120.1	(26.2)	112.8	15	102.4	(35.5)	109.6	13	.09	.77	-.12
Adaptive Behavior	1,2	74.5	(17.7)	69.6	15	63.1	(20.7)	68.0	13	.05	.82	-.09
Motor Total	1,2	99.1	(18.3)	94.4	15	80.3	(21.2)	85.0	13	1.90	.18	-.51
Communication	1,2	64.3	(18.3)	57.6	15	52.9	(25.1)	59.6	13	.08	.78	.11
Cognitive	1,2	49.2	(21.5)	42.4	15	38.6	(22.7)	45.4	13	.18	.68	.14
TOTAL	1,2	407.2	(93.3)	376.9	15	337.3	(116.3)	367.7	13	.08	.79	-.10
• **Exploration/Play Developmental Age (In Months)**	1,2	18.5	(4.5)	17.6	13	16.0	(6.8)	17.0	11	.04	.84	-.13
												$\bar{x}$ ES = -.15

Effect size (ES) is defined here as the difference between the groups (High minus low) on the $\bar{x}$ scores, divided by the standard deviation of the Low Intensity Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of effect size).

' Statistical analysis for BDI scores were conducted using raw scores.

* Covariates: 1 = Family Resource Scale; 2 = BDI Gross Motor Raw

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Battelle pretest gross motor raw scores and FRS pretest scores were used as covariates. In reviewing the BDI domain scores for Reassessment #2, the mean domain and total scores were not significantly different, reflecting overall negligible effect sizes.

The developmental play ages of children based on the videotapes of spontaneous, independent play are also reported in Table 1.14. Adjusted mean scores for the two groups revealed no significant differences, with a negligible effect size.

Subgroup analysis. As previously mentioned, subjects were enrolled in the study provided that they were under 30 months of age. Therefore, children who were enrolled as infants received two years of either the low or high intensity intervention. Children who were between two and three years of age at enrollment received one year of the assigned intervention and then graduated from the program. To determine whether duration of intervention was related to outcomes, a subgroup analysis was performed by dividing the high and low intensity groups into those who received two years of the designed intervention and those who received only one year of the intervention. These results are presented in Table 1.15. The subgroup analysis resulted in no statistically significant interaction effect between duration of intervention and intensity on BDI scores. Those who received two years of high intensity intervention did not score significantly better than those who participated in the low intensity intervention for two years. Aside from the interaction effects which were investigated, there appears to be a tendency for younger children, regardless of group assignment, to score better on the BDI than children enrolled at an older age.

Results of Reassessment #3. Table 1.16 summarizes the Battelle Developmental Inventory and Vineland Adaptive Behavior Scales scores for Reassessment #3. Twenty-four subjects received the battery; one subject requested to be dropped from the study, and six subjects were unable to be located at the time of Reassessment #3.

Again, no statistically significant differences were found between low versus high intensity groups. Effect sizes generally were negative, with a mean effect size of -.15.

Table 1.15

Age at Enrollment Comparison of Child Outcome Measures Collected at Reassessment #2 for the New Orleans V.I. Intensity Study

Variable		Low Intensity			High Intensity			Group	Age Status	Groups by Age
		Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n	p Value	p Value	p Value
CA at Pretest	Younger	7.1	(4.7)	7	4.9	(2.2)	7			
	Older	22.9	(7.3)	8	28.6	(6.1)	5			
• **Battelle Developmental Inventory (BDI)**										
Personal/Social	Younger	129.2	(27.6)	7	140.3	(25.5)	7	.69	.04	.58
	Older	89.9	(36.3)	8	82.2	(34.8)	5			
Adaptive	Younger	74.2	(17.2)	7	82.0	(13.1)	7	.48	.20	.72
	Older	59.9	(20.6)	8	63.2	(22.4)	5			
Gross Motor	Younger	56.0	(4.3)	7	55.1	(11.8)	7	.54	.62	.60
	Older	54.2	(11.3)	8	49.1	(11.8)	5			
Fine Motor	Younger	39.4	(3.6)	7	44.6	(6.0)	7	.98	.14	.17
	Older	33.1	(14.6)	8	27.6	(14.8)	5			
Communication	Younger	60.3	(15.7)	7	64.3	(13.3)	7	.62	.73	.94
	Older	54.5	(18.9)	8	59.7	(30.3)	5			
Cognitive	Younger	56.4	(8.4)	7	60.1	(8.1)	7	.71	.08	.35
	Older	35.8	(29.1)	8	25.1	(31.5)	5			
Total	Younger	415.4	(72.2)	7	446.5	(67.2)	7	.83	.11	.51
	Older	327.3	(122.4)	8	313.8	(139.0)	5			

Covariates included chronological age at pretest and BDI gross motor raw score.

Table 1.16

Reassessment #3 Measures of Child Functioning for Alternative Intervention Groups for NO/VI Study

Variable	Covariates♦	Low Intensity				High Intensity						
		$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES^
• **Average time between Pretest and Reassessment #3 (in months)**		39.5	(3.4)		13	39.9	(1.7)		11	.11	.74	.12
• **Age in months at Reassessment #3**		55.9	(9.9)		13	55.4	(13.6)		11	.01	.91	-.05
• **Battelle Developmental Inventory (BDI)**												
Personal/Social	1,2	136.8	(34.5)	130.8	13	118.5	(43.3)	124.4	11	.18	.68	-.19
Adaptive Behavior	1,2	83.6	(18.0)	79.9	13	75.3	(24.5)	79.0	11	.02	.90	-.05
Motor Total	1,2	113.6	(25.3)	106.6	13	87.3	(25.5)	94.3	11	2.11	.16	-.49
Communication	1,2	79.6	(25.1)	73.2	13	65.2	(29.0)	71.6	11	.04	.84	-.06
Cognitive	1,2	66.5	(29.9)	58.3	11	56.3	(24.7)	64.6	11	.58	.46	.21
TOTAL	1,2	482.2	(125.9)	450.8	13	398.5	(141.1)	430.0	11	.24	.63	-.17
• **Vineland Adaptive Behavior Scale (Standard Score)**												
Communication	3	99.2	(14.6)	93.2	12	84.4	(30.3)	90.4	11	.09	.77	-.19
Daily Living	3	91.0	(14.3)	83.6	12	79.0	(32.8)	86.4	11	.10	.76	.20
Socialization	3	97.4	(11.5)	93.2	12	86.0	(22.3)	90.2	11	.18	.68	-.26
Motor Skills	3	82.3	(15.6)	78.5	12	66.9	(25.5)	70.6	11	.74	.40	-.51
												$\bar{x}$ ES = -.15

♦ 1 = BDI gross motor raw, 2 = FRS Raw, 3 = BDI DQ Total

Effect Size (ES) is defined here as the difference between the groups (high intensity minus low intensity) on the $\bar{x}$ score divided by the standard deviation of the Low Intensity Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for more general discussion of the concept of Effect Size).

Educational services follow-up at Reassessment #3. Information was gathered via parent report regarding the type of educational services their child received during the year. Such data was of interest to determine if the intervention possibly influenced later placement and degree of special services. A summary of the educational placements is presented in Table 1.17. There was a variety of educational placements and degrees of mainstreaming among both groups. Neither group appeared to differ significantly from the other.

Table 1.17
Educational Services Data Collected at Reassessment #3 for NO/VI Study

Variable	Low Intensity Group (n = 13)	High Intensity Group (n = 11)
GRADE		
Preschool/Kindergarten	9	9
Elementary		
No Educational Services	4	2
Don't Know		
Daycare		
TYPE OF PLACEMENT		
VI Only	1	3
Self-contained	2	3
Disabled/non-mixed	1	2
Regular program	3	1
Unknown	2	
Mainstreaming		
Not mainstreamed	1	1
Partial mainstreamed	4	7
All day	1	1
Unknown	3	
Not applicable	4	2

Results of Reassessment #4. As of July 1, 1993, there were 29 active subjects participating in the study to date. Also at this time, 27 subjects had completed the Reassessment #4 battery. The results of the child outcome data analysis are found in Table 1.18. There were no significant differences found between groups on the Battelle Developmental Inventory, the Vineland Adaptive Behavior Scores, the Boehm Test of Basic Concepts, or the Social Skills Rating System. Negative effect sizes resulted for the majority of the subscales, with a mean effect size of -.03. When viewing the sample as a whole, these children generally performed within one standard deviation of the mean on the Vineland and the SSRS. When converted to developmental quotients, performance on the BDI was within one standard deviation of the mean for the Personal/Social domain, and 1.0 to 1.5 standard deviations below the mean for the other domains.

Table 1.18

Reassessment #4 Measures of Child Functioning for Alternative Intervention Groups for NO/VI Study

		Low Intensity				High Intensity						
Variable	Covariates◆	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES^
• **Average time between Pretest and Reassessment #4**		49.5	(2.8)	49.5	15	50.7	(2.8)	50.7	12	1.21	.28	.42
• **Age in months at Reassessment #4**		63.9	(10.1)	63.9	15	65.8	(15.3)	65.1	12	.06	.82	.11
• **Battelle Developmental Inventory (BDI)**												
Personal/Social	1	140.7	(37.2)	135.3	15	127.3	(30.4)	132.6	12	.05	.83	-.07
Adaptive Behavior	1	88.4	(25.9)	84.5	15	80.5	(18.0)	84.4	13	.00	.98	-.004
Motor Total	1	116.1	(30.3)	111.1	15	101.3	(27.5)	106.2	12	.23	.64	-.16
Communication	1	84.3	(27.2)	79.0	15	71.2	(27.1)	76.5	12	.08	.78	-.09
Cognitive	1	74.1	(29.6)	68.2	15	59.4	(28.6)	65.3	12	.10	.76	-.10
TOTAL	1	508.0	(143.8)	483.4	15	439.9	(118.7)	464.6	12	.17	.68	-.13
• **Vineland Adaptive Behavior Scale (Standard Score)**												
Communication	2	93.7	(18.5)	91.9	14	85.7	(22.1)	87.5	12	.30	.59	-.24
Daily Living	2	89.3	(22.8)	85.4	14	78.6	(29.8)	82.5	12	.09	.77	-.13
Socialization	2	92.6	(17.9)	90.3	14	85.6	(23.6)	87.8	12	.89	.76	-.14
Composite	2	84.3	(21.5)	83.7	14	48.6	(26.8)	78.6	12	.03	.89	-.24
• **Boehm Basic Concepts, Total Score**	2	32.1	(16.7)	28.2	14	14.4	(20.3)	18.3	12	2.51	.13	-.59
• **Social Skills Rating System (Standard Scores)**												
Total (parent)	3	45.9	(11.6)	45.8	15	49.0	(22.4)	49.1	10	.28	.61	.28
Problem Behavior (parent)	3	11.5	(4.8)	11.5	15	9.7	(5.9)	9.7	10	.69	.41	.38
Total (teacher)	3	39.6	(15.3)	39.4	11	35.2	(14.5)	35.4	9	.35	.56	-.26
Problem Behavior (teacher)	3	6.6	(6.5)	6.6	11	6.1	(6.1)	3.4	9	.04	.85	.49

$\bar{x}$ ES = -.05

◆1 = BDI gross motor raw score at pretest, 2 = Battelle Total DQ (developmental age ÷ chronological age) at pretest

^Effect Size (ES) is defined here as the difference between the groups (high intensity minus low intensity) on the $\bar{x}$ score divided by the standard deviation of the Low Intensity Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for more general discussion of the concept of Effect Size).

Educational services follow-up at Reassessment #4. Educational placement was also analyzed at the time of Reassessment #4 (see Table 1.19). At that point in time the majority of the children in both groups were in preschool or kindergarten, and a third of the children were in elementary grades. The children receiving no services are preschool age and are not in school due to parent preference. Most of the placements were in typical classrooms, with more children in the low intensity group receiving services in a regular classroom environment. It is difficult to discern if intervention influenced child placement by the time of Reassessment #4.

Reassessment #5. As of July, 1993, there were 30 active subjects in the study, and reassessment #5 data were collected for 26 of these subjects. The results of reassessment #5 data are reported in Tables 1.20. The scores in the area on motor development as measured by the BDI showed statistically significant differences in the fine motor subdomain in favor of the low intensity group. Gross motor scores were not statistically significantly different. Since only the subscales which do not require visual stimuli were administered for the McCarthy and TOLD-P, II, only raw scores were obtainable; therefore, analyses for these measures were based on raw scores. No statistically significant differences were found between groups, with the effect sizes showing a negative trend. Analyses of Vineland and SSRS scores resulted in no statistically significant differences, and the direction of the effort sizes were mixed. The mean effect size across all measures was -.14.

Table 1.19

Educational Services Data Collected at Reassessment #4

Variable	Low Intensity Group (n = 15)	High Intensity Group (n = 12)
GRADE		
Preschool/Kindergarten	13	6
Elementary	1	3
No Educational Services	1	2
TYPE OF PLACEMENT		
Typical	10	4
Self-contained ½ day	0	3
Self-contained full day	3	4
Resource	1	0
Residential	0	0
No placement	1	1

Educational services at Reassessment #5. At the time of reassessment #5, approximately two-thirds of the children were still in preschool or kindergarten and one third were elementary school age (see Table 1.21). The majority of children were in regular classrooms, with resource room and/or therapy support services. The number of children receiving services in self-contained settings was balanced across

Table 1.20

Reassessment #5 Measures of Child Functioning for Alternative Intervention Groups for NO/VI Study

		Low Intensity				High Intensity						
Variable	Covariates[a]	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	ANCOVA F	p Value	ES[b]
Average time between Pretest and Reassess. #5		60.4	(7.8)		16	62.8	(1.9)		12	1.06	.31	.31
Age in months at Reassess. #5		74.1	(10.8)		16	74.7	(12.2)		12	.02	.90	.06
Battelle Developmental Inventory (BDI)												
Gross Motor	1	76.6	(14.5)	74.5	16	63.7	(17.8)	65.8	13	2.35	.14	-.60
Fine Motor	1	60.1	(17.8)	59.0	16	43.9	(14.1)	44.6	13	4.99	.03	-.81
McCarthy												
Verbal Memory	1	17.8	(5.7)	16.9	16	13.6	(5.3)	14.4	13	7.90	.01	-.44
Verbal Fluency	1	22.9	(21.9)	20.8	16	13.7	(9.5)	15.8	13	.63	.43	-.23
Opposite Analogies	1	10.3	(5.3)	9.4	16	8.8	(4.2)	9.6	13	.01	.91	.01
Quantitative Scale	1	30.0	(14.7)	26.8	16	22.1	(16.6)	25.3	13	.11	.74	-.10
TOLD-II												
Oral Vocabulary	1	10.4	(8.6)	9.3	16	6.4	(6.2)	7.5	13	.44	.51	-.21
Sentence Imitation	1	16.3	(10.6)	14.2	16	9.8	(9.2)	11.8	13	.72	.40	-.23
Grammatic Completion	1	12.8	(10.7)	10.7	16	9.2	(10.4)	11.2	13	.03	.86	.05
Word Discrimination	1	13.0	(7.4)	11.8	16	7.2	(9.0)	8.4	13	1.41	.24	-.46
Vineland (standard scores)												
Communication	2	98.2	(20.4)	97.8	16	87.0	(22.2)	87.5	13	1.48	.23	-.50
Daily Living	2	85.1	(24.5)	82.4	16	81.3	(23.3)	84.0	13	.03	.86	.07
Socialization	2	92.2	(18.6)	90.8	16	85.8	(18.4)	87.1	13	.26	.61	-.20
Adaptive Composite	2	90.3	(22.4)	89.1	16	78.0	(25.5)	79.1	13	1.14	.30	-.45
Social Skills Rating System (standard scores)												
Parent:												
Social Skills	2	93.5	(17.7)	94.0	15	98.0	(27.7)	97.5	11	.13	.72	.20
Behavior Problems	2	102.8	(13.5)	104.0	15	101.4	(13.0)	100.2	12	.48	.49	.28
Teacher												
Social Skills	2	94.3	(17.2)	93.0	14	89.5	(9.6)	90.9	10	.12	.73	-.12
Behavior Problems	2	104.6	(14.4)	106.1	14	104.6	(8.8)	103.1	10	.35	.55	.21

$\bar{x}$ ES = -.24

Table 1.21

Educational Services Data Collected at Reassessment #5 for NO/VI Study

Variable	Low Intensity Group (n = 13)	High Intensity Group (n = 11)	p
GRADE			
Preschool	2	4	.31
Kindergarten	7	4	.45
Elementary	5	3	.63
No Educational Services		1	.49
TYPE OF PLACEMENT			
Regular, no special services	1	2	.54
Regular with therapy	7	4	.45
Regular with resources	0	0	.92
Regular with therapy & resources	1	1	.87
Self-contained (less than 3 hrs)	0	1	.49
Self-contained (3 or more hrs.)	4	3	.87
Homebound	0	0	.92
Residential	0	0	.92
Undetermined	1		.64
No educational placement		1	

both groups. The results of these placements are in accordance with the general trend toward integration and least restrictive environments. No significant differences between groups appeared in regard to educational placement.

__Reassessment #6__. To date, reassessment #6 data have been collected for 26 subjects (see Table 1.22). Scores on child outcome measures generally favored the low intensity group, although there were few statistically significant differences. An analysis of raw scores for two for the four verbal subscales of the McCarthy reflex statistically significant (p ≤ .10) differences in favor of the low intensity group. One of the four TOLD, P-II subscales and the Communication Scales of the Vineland were statistically significantly higher for the low intensity group. No statistically significant differences were reported for the Hill Performance Scale or the Social Skills Rating System. Overall, test scores remained consistent with the past reassessment 8.

__Educational services at Reassessment #6__. Educational services data on 25 of the 26 subjects who have participated in reassessment #6 are presented in Table 1.23. Most of the children are now school age, with placements being primarily between a self-contained elementary special education classroom and a regular elementary classroom. Based on data collected thus far, it appears that more children from the high intensity groupo are in self-contained placements.

Table 1.22

Reassessment #6 Measures of Child Functioning for Alternative Intervention Groups for NO/VI Study

		Low Intensity				High Intensity						
Variable	Covariates*	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES*
Average time between Pretest and Reassessment #6		73.9	(2.8)		14	76.2	(5.3)		12	1.89	.35	.82
Age in months at Reassessment #6		89.1	(11.3)		14	90.8	(13.0)		12	.13	.74	.15
Hill, ptI	4	29.6	(6.7)	28.2	14	25.3	(8.0)	26.7	12	.34	.57	-.22
Hill, ptII	4	31.4	(5.7)	30.3	14	23.7	(11.7)	24.8	12	2.42	.13	-.96
Hill, ptIII	4	30.6	(7.1)	29.0	14	25.3	(8.4)	26.9	12	.64	.43	-.30
Hill, ptIV	4	30.6	(7.5)	29.2	14	23.0	(13.0)	24.4	12	1.43	.24	-.64
Hill Total	4	116.8	(38.9)	109.7	14	97.2	(38.7)	104.3	12	.16	.70	-.14
McCarthy												
Verbal Memory	1	21.1	(4.4)	20.6	14	16.7	(5.4)	17.2	12	4.35	.05	-.77
Verbal Fluency	1	26.6	(7.6)	25.6	14	20.0	(7.7)	20.9	12	4.68	.04	-.62
Opposite Analogies	1	13.6	(4.7)	13.1	14	11.8	(4.1)	12.4	12	.28	.60	-.15
Quantitative Scale	1	38.2	(13.0)	36.5	14	29.8	(17.6)	31.5	12	1.12	.30	-.38
TOLD, P-II												
Oral Vocabulary	1	16.6	(9.1)	15.7	14	10.4	(10.0)	11.3	12	1.80	.19	-.46
Sentence Imitation	1	20.4	(10.3)	19.4	14	15.9	(11.2)	17.0	12	.44	.51	-.23
Grammatic Completion	1	27.0	(9.1)	21.0	14	14.3	(11.9)	15.3	12	2.63	.12	-.63
Word Discrimination	1	17.4	(4.2)	17.1	14	12.1	(9.0)	12.3	12	3.05	.09	-1.14
Vineland												
Communication Standard Sc.	2	104.3	(20.0)	102.4	14	83.1	(24.5)	84.9	12	4.81	.04	-.88
Daily Living Standard Sc.	2	94.2	(18.8)	93.1	14	84.7	(30.0)	86.3	12	.53	.48	-.36
Socialization Standard Sc.	2	98.9	(15.0)	97.4	14	93.2	(23.2)	94.7	12	.15	.71	-.18
Score	2	97.3	(23.8)	95.3	14	85.5	(28.8)	87.4	12	.66	.42	-.33
Social Skills Rating System (standard Scores)												
Parent:												
Social Skills		96.5	(17.6)		12	98.5	(27.0)		13	.05	.83	.11
Behavior Problems		99.3	(20.5)		12	100.6	(12.2)		13	.04	.85	.06
Teacher:												
Social Skills	3	101.2	(15.1)	99.8	13	90.8	(9.4)	92.3	10	2.02	.17	-.50
Behavior Problems	3	100.8	(13.4)	102.5	13	99.6	(5.9)	97.9	10	1.35	.26	-.34

1 = BDI total raw score, pretest; 2 = DQCA; 3 = Occupation of mother at pretest; 4 = BDI Gross motor standard score pretest.

Table 1.23

Educational Services at Reassessment #6 for NO/VI Study

Placement Options	Low Intensity (n = 13)	High Intensity (n = 12)
Self-Contained Preschool		1
Regular Preschool		
Self-Contained Elementary Education	2	1
Resource Elementary Education	1	3
Regular Elementary Education	10	5
Residential		1
Unknown		1

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Effects of Alternative Forms of Intervention on Measures of Family Functioning

Data were reported for one year and two years following enrollment. Previously-described procedures were again implemented in the selection of covariates.

Reassessment #1. Table 1.24 represents results of analysis involving family functioning measures. One family declined to complete the measures, therefore data from the high intensity group included 13 rather than 14 subjects. Analysis of covariance was performed using pretest scores for BDI gross motor raw score and Family Resource Scale. No significant differences were found between groups on any of the family measures. In reviewing effect sizes based on the measures of stress, small but positive effect sizes resulted for the total score of the PSI child subdomain and total score, while negative effect sizes resulted for the FRS, FSS, and FACES III scores. However, these negative effect sizes were also negligible. The mean effect size for all family measures at Reassessment #1 was -.06.

Table 1.24
Reassessment #1 Measures of Family Functioning for Alternative Intervention Groups for NO/VI Intensity

		Low Intensity Group					High Intensity Group							
Variable	Covariates◆	$\bar{x}$	(SD)	Adj $\bar{x}$	%ile	n	$\bar{x}$	(SD)	Adj $\bar{x}$	%ile	n	ANCOVA F	p Value	ES
• Average Length of Intervention	12.7	(2.0)			17	12.3	(.5)			14		.46	-.20	
• **Parent Stress Index (PSI)**** Child Related Range (50 to 235)	1,2	107.2	(15.5)	109.7	75	17	109.5	(21.4)	107.0	70	13	.12	.73	+.17
Parent Range (47 to 270)	1,2	124.3	(24.2)	123.6	56	17	123.5	(20.9)	124.2	56	13	.00	.96	-.02
• **Family Adaptation and Cohesion Evaluation Scales (FACES)**														
Adaptability	1,2	23.6	(10.0)	24.5		16	23.0	(3.8)	22.0		13	.57	.46	-.04
Cohesion	1,2	40.1	(10.2)	38.9		16	38.1	(19.1)	39.3		13	.03	.86	-.20
• **Family Resource Scale (FRS)***°	1,2	129.6	(10.8)	123.3	59	17	113.4	(20.0)	119.7	50	13	.45	.45	-.33
• **Family Support Scale(FSS)***°	1,2	35.6	(9.4)	34.2	71	16	29.7	(8.4)	31.1	63	13	.69	.41	-.33
• **Family Support Scale # of Sources**	1,2	15.9	(3.1)	16.1		16	16.8	(2.4)	16.7		13	.24	.63	+.19
														$\bar{x}$ ES = -.06

Effect size (ES) is defined here as the difference between the groups (high intensity minus low intensity) on the $\bar{x}$ scores, divided by the standard deviation of the Low Intensity Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a general discussion of the concept of effect size).

◆ Covariates: 1 = BDI Gross Motor Raw Score; 2 = Family Resource Scale Raw Score

* A low raw score and/or a high percentile score indicates lower stress level, and a positive effect size is more desirable.

* Statistical analysis and effect size (ES) estimates for PSI was d on raw scores where low raw scores and positive ES are most desirable.

* A low raw score and/or a low percentile score indicates lower stress level.

* Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher percentiles and positive ESs are considered better.

° No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on all pretests collected as a part of the Longitudinal Studies.

Analysis of parent-child interaction videotapes. The Multi-pass scheme (Marfo, 1989) was implemented for the coding of the parent-child interaction tapes. Multi-pass was designed primarily to study the notion of maternal directiveness in relation to the responses of parent and child to one another. Multi-pass uses an event-based coding system targeting four types of parental directive behavior: (1) turn taking control, (2) response control, (3) topic control, and (4) inhibitive/intrusive control. The system also allows for a close analysis of verbal directiveness. Videotapes were sent directly to the author of Multi-pass to ensure accurate coding. Analysis of the raw data was conducted by the EIFI site coordinator. Multi-pass provides data on 40 specific behaviors; therefore, related variables were combined to reflect the four dimensions of parental directive behavior. Additionally, dimensions of child responsiveness were also developed by combining related behaviors.

Table 1.25 reports the results of preliminary Multi-pass scoring comparing the low versus high intensity groups. To date, 14 of the 31 Reassessment #1 videotapes have been coded. Due to this small number of subjects, only t-tests are reported rather than analysis of covariance. Results show that the groups did not differ significantly in regard to turn taking control of parent (degree of balance in participation between parent and child), response control parent (extent to which parent behavior is directed at attempting to get the child to respond), response control of child (extent to which child behavior is directed at attempting to get the parent to respond), frequency of parent imperative, embedded, implied directives, frequency of child's compliance with these directives, frequency of parent instructional behaviors (labels, expands, gives and requests information, models, and reinforces). The high-intensity group scores were significantly higher ($p \leq .05$) on the frequency of parental inhibitions and intrusions (verbal or nonverbal behavior directed at stopping the child from engaging in an activity or behavior that is not considered to be dangerous/undesirable, or imposing the parental agenda at the cost

Table 1.25

Year #1 Reassessment Measures of Parent-Child Interaction for Alternative Intervention Groups for NO/VI Intensity Study

	Low Intensity			High Intensity				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES^
MULTI-PASS*								
• **Parent Behavior**								
Turn-Taking Control·	1.64	(.4)	7	1.67	(.4)	7	.86	-.08
Response Control·	5.58	(1.9)	7	4.35	(1.6)	7	.21	.65
Inhibitions/Intrusions·	.52	(.2)	7	.25	(.1)	7	.00	1.35
Imperatives/Implied·	2.90	(1.1)	7	2.71	(2.7)	7	.68	.17
Instructional Behaviors	4.43	(2.3)	7	3.82	(1.0)	7	.56	-.27
• **Child**								
Response Control·	.59	(.5)	7	.27	(.2)	7	.18	.64
Compliance with Inhibitions	.32	(.2)	7	.17	(.1)	7	.13	.75
Compliance with Directions	1.88	(.8)	7	1.46	(.8)	7	.33	-.53
							$\bar{x}$ ES =	+.35
PARENT/CAREGIVER INVOLVEMENT SCALE								
• **Average Rating**								
Amount	2.77	(.6)	16	2.94	(.4)	13	.39	.28
Quality	3.64	(.7)	16	3.77	(.5)	13	.59	.18
Appropriateness	3.81	(.8)	16	3.72	(.6)	13	.73	-.12
• **General Impression**								
Availability	4.00	(1.0)	16	4.0	(.8)	13	1.00	0
Acceptance	3.75	(1.1)	16	4.0	(.8)	13	.49	.24
Atmosphere	3.50	(.9)	16	3.85	(.8)	13	.29	.39
Enjoyment	3.44	(.9)	16	3.54	(.7)	13	.74	.11
Learning Environment	3.31	(1.2)	16	3.31	(1.0)	13	.99	0
Mean General Impression	3.60	(.9)	16	3.74	(.7)	13	.66	.15
PARENTAL BEHAVIOR RATING SCALE								
• Affective relationship w/child	3.09	(.7)	14	3.13	(.6)	13	.86	.06
• Child Orientation	3.05	(.9)	14	3.08	(.7)	13	.92	.03
• Performance orientation	3.14	(.7)	14	3.26	(.6)	13	.67	.17
								$\bar{x}$ = .12

^ Effect Size (ES) is defined here as the difference between the groups (high intensity minus low intensity) on the $\bar{x}$ score divided by the standard deviation of the Low Intensity Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for more general discussion of the concept of Effect Size).

* All scores reflect frequency of occurrences divided by number of minutes recorded.

· Higher scores associated with higher level of directiveness.

of the child's interests). However, it should be noted that this was a very low frequency variable. Associated with the frequency of parental inhibiting behaviors is the frequency of child's compliance with parental inhibitions. Mean scores for compliance in the high intensity group were lower (though not significantly so), most likely due to the lower number of parental inhibitions which were directed toward them.

Reassessment #1 parent-child interaction tapes were also analyzed using the Parent/Caregiver Involvement Rating Scale (Farran et al., 1986). This scale is designed to assess the behavior of the caregivers (in this case, mothers) during play interactions. Behavior is rated in regard to the amount displayed, the quality, and the appropriateness of 11 behaviors: physical involvement, verbal involvement, responsiveness, play interaction, teaching behavior, control activities, directives given, relationship among activities, positive statements, negative statements, and goal setting. The tapes were rated by coders trained by Farran, who demonstrated strong adherence to standard procedures. The average rating scores reported reflect averages of the 11 behaviors. Amount was scored based on a 5-point Likert-type scale with a "3" being the most desirable score. T-tests were used to analyze between-group differences. As shown in Table 1.25, no differences were found between the groups.

The coders using the Parent/Caregiver Involvement Scale also rated his/her general impressions of the caregiver depicted in the videotape. This included availability of the parent to the child, acceptance of the child, general atmosphere of the interaction, amount of enjoyment between parent and child, and parent's provision of a learning environment. These characteristics are also scored using a 5-point Likert-type scale, with "1" being poor and "5" being best. Scores for both groups were in the moderate range, with no significant differences between groups. Finally, a mean general impression score was calculated, revealing a minimal effect size in favor of the high intensity group.

Finally, the results of the Parental Behavior Rating Scale are presented in Table 1.25. The tapes were scored by Mahoney, the developer of the rating system. Three factor scores are reported, based on a factor analysis performed with the combined EIRI data set. No significant differences were found between groups in regard to the parent's affective relationship with the child, the parent's affective relationship with the child, the parent's orientation/ responsivity to the child, or the parent's orientation toward the child.

Children with Visual Impairments vs. Sighted Peers. Data collected from this study also were used to learn more about the impact of a child's visual impairment on the mother's interaction style. For example, visual impairments in children have been reported to impede the development of positive mother/child interaction (Van Hasselt, Herson, Moore, & Simon, 1986). It was hypothesized that though mothers of children with visual impairments were no different in quality and appropriateness of their interaction compared to mothers of sighted children, mothers of VI children would use different interactional strategies.

Mothers of thirty-one children with visual impairments were compared with a sighted comparison group drawn from subjects in the EIFI data set, matched by chronological age (see Table 1.26). The mean developmental quotient for the children with visual impairments was 80.0, and the mean DQ for the sighted comparison group was 86.5; this difference was not considered to be statistically significant. There were no statistically significant differences on family measures or socioeconomic status. Mother's age in the VI group were statistically significantly younger, however, this was not found to correlate with the dependent variables.

Maternal interaction behaviors were evaluated using the Parental Behavior Rating Scale (PBRS; Mahoney & Powell, 1988) and the Parent/Caregiver Involvement Scale (PCIS; Farran, Kasari, Comfort, & Jay, 1986). T-tests were used to examine between group differences. Results indicated no statistically significant differences between the two groups on the PBRS (see Table 1.27). The two groups also scored similarly on the Quality Scale and the Appropriateness Scale of the P/CIS (see Table 1.28). A statistically significant difference was found in the Amount scale of the mothers'

Table 1.26
Comparability of Groups (VI vs. non-VI mother-child dyads) for Sociodemographic Variables Based on t-Tests

	VI[a] Group			PSIC[b] Non-VI Group				PBRS[c] Non-VI Group			
Variable	Mean	SD	N	Mean	SD	N	p[d]	Mean	SD	N	p[d]
DQ[f]	80.0	(.3)	31	86.0	(.1)	31	.25	87.0	(.1)	31	.20
Child Age	33.6	(13.6)	31	33.7	(13.6)	31	.97	33.3	(13.7)	31	.99
% Female	52.0		31	52.0	(51.0)	31	1.00	47.0		31	.81
Years of Education	13.1	(2.6)	31	13.9	(2.1)	30	.19	13.7	(2.2)_	31	.30
% Family Intact	73.0		30	90.0		31	.29	87.0		31	.12
% Caucasian	81.0		31	90.0		31	.29	87.0		31	.50
% Employed outside the home	27.0		30	52.0		29	.39	53.0		30	.31
Family Income	27,086.00	(19,435.0)	29	26,120.0	(17,182.0)	29	.84	27,327.0	(19,190.0)	29	.86
Mother's Hours Worked Per Week	17.2	19.2	30	13.0	(19.2)	29	.41	14.1	(18.4)	31	.60
Mother Age	26.2	5.9	31	28.9	(4.7)	31	.05	28.5	(4.3)	31	.05
Parenting Stress Index[e]	233.5	33.4	30	228.7	(40.4)	30	.61	229.9	(41.5)	31	.90
Family Support Scale[e]	31.1	9.0	30	32.3	(11.8)	30	.67	31.2	(11.2)	31	.96
Family Resource Scale[e]	124.3	18.4	30	123.8	(17.9)	30	.92	124.8	(14.7)	31	.97

Notes:
a. VI: Visually impaired
b. PCIS: Parent/Caregiver Involvement Scale
c. PBRS: Parent Behavior Rating Scale
d. Probability for comparison with VI group
e. Higher scores indicate greater stress, support, or resources
f. Age equivalent ÷ chronological age x 100

Table 1.27
Comparability of Groups (VI vs. Non-VI Mother-Child Dyads) for Parental Behavior Rating Scale (PBRS)

	Non-VI Group			VI Group			
t-test for:	Mean	SD	N	Mean	SD	N	p
Perform Orientation	2.78	.58	31	2.85	.65	31	.61
Responsivity	3.27	.91	31	3.19	1.26	31	.70
Affect	3.17	.65	31	3.13	.62	31	.75

Note: To aid interpretation, an average score based on the 5-point scale is reported. Analysis was performed on total raw scores.

Table 1.28
Comparability of Groups (VI vs. Non-VI Mother-Child Dyads) for Parent/Caregiver Involvement Scale (PCIS)

	Non-VI Group			VI Group			
t-test for:	Mean	SD	N	Mean	SD	N	p
Quality	4.00	.62	31	3.99	.65	31	.91
Appropriateness	4.15	.64	31	4.06	.66	31	.60
AMOUNT	**2.60**	**.36**	**31**	**2.83**	**.42**	**31**	**.02**
Physical Involvement	**1.52**	**.81**	**31**	**2.19**	**1.11**	**31**	**.01**
Verbal Involvement	3.42	.72	31	3.74	.63	31	.07
Control Activity	**2.52**	**1.09**	**31**	**3.26**	**1.03**	**31**	**.01**
Responsiveness	4.19	.79	31	4.10	.91	31	.66
Play Interaction	3.74	.96	31	3.94	1.03	31	.45
Teaching Behavior	1.74	.96	31	1.74	.97	31	1.00
Directiveness	2.71	.74	31	3.03	.88	31	.12
Relationship among activities	4.06	1.09	31	3.97	.91	31	.71
Positive Regard	1.87	.85	31	1.87	.91	31	.71
Negative Regard	1.35	.61	31	1.42	.56	31	.67
Goal Setting	1.45	1.06	31	1.87	1.09	31	.13

Note: To aid interpretation, an average score based on the 5-point scale is reported. Analysis was performed on total raw scores for amount, appropriateness, and quality.

interactions, with the mothers of children in the VI group having higher scores compared to mothers in the non-VI group ($p = .021$) (see Table 1.27). Specifically, mothers in the VI group scored higher in regard to physical involvement, amount of control activities, and verbal involvement. Goal setting and directiveness were also greater for the VI group, though differences were not statistically significant.

To investigate the relationship between severity of visual impairment and maternal interaction behaviors, children with visual impairments were rated according to the degree of vision loss (mild, moderate, and severity). Neither the PCIS or the PBRS scales demonstrated statistically significant correlations between the degree of visual impairment and maternal interaction behaviors.

The results of these analyses can be interpreted as being in agreement with Kekelis and Anderson's (1984) and Imamura's (1985) conclusions that the mother's interaction is structured to encourage the visually impaired child to take a more active role, as demonstrated by the greater amount of maternal interaction behaviors revealed on the PCIS. However, the presence of a vision loss in the children does not necessarily result in poorer maternal interaction behaviors, as demonstrated by the finding of no statistically significant differences on the PBRS or Appropriateness and Quality of interaction measured by the PCIS. This is contrary to past studies which emphasize the detrimental effects of a vision loss. This could be due to differences in sample size, since previous studies were based on small group sizes. Second, this study used two maternal interaction scales which to date have not been typically used with children who are visually impaired. Third, improvements in current early intervention services compared to those available one to two decades ago may be positively impacting mother/child interaction.

This study was submitted for publication in May, 1994 to the Journal of Visual Impairment and Blindness. To date, no work on its acceptance has been received.

Reassessment #2. The core family measures were again administered two years from date of pretest. The parents of one subject again refused to complete the family measures, therefore data on only 12 of the 13 subjects from the high intensity intervention were available for analysis. As depicted in Table 1.29, no statistically significant differences were found between intervention groups on most of the family measures. The average effect size for all the family functioning measures at Reassessment #2 was -.05. Percentile rank scores for the PSI, FRS, and FSS are also reported in the table. These scores reflect average levels of stress, resources, and supports for the families is a whole.

Table 1.29

Year 2 Reassessment Measures of Family Functioning for Alternative Intervention Groups for N.O./VI Intensity Study

Variable	Covariate[5]	Low Intensity Group $\bar{x}$	(SD)	Adj.$\bar{x}$	%ile	n	High Intensity Group $\bar{x}$	(SD)	Adj.$\bar{x}$	%ile	n	ANCOVA F	p Value	ES
Average time between pretest and posttest		26.6	(3.1)			15	26.8	(5.0)			12		.93	
Parent Stress Index (PSI)**														
Child Related (Range 50 to 250)	1,2	103.0	(13.0)	105.3	65	15	115.0	(21.4)	112.7	79	12	.95	.34	-.57
Parent (Range 54 to 270)	1,2	121.1	(15.9)	123.9	56	15	131.6	(24.4)	128.7	65	12	.29	.60	-.30
Family Adaptation and Cohesion Evaluation Scales (FACES)*														
Adaptability	1,2	22.3	(4.8)	22.8		15	19.9	(4.6)	19.4		11	2.12	.16	-.71
Cohesion	1,2	39.3	(5.2)	37.4		15	38.4	(7.4)	40.3		11	1.31	.26	.56
Family Resource Scale (FRS)**	1,2	130.8	(13.5)	124.2	73	15	121.0	(20.1)	127.6	55	12	.35	.56	.25
Family Support Scale Total (FSS)**	1,2	30.9	(8.0)	28.3	51	15	29.2	(11.1)	31.8	67	12	.87	.36	.44
FSS Sources*	1,2	14.5	(2.6)	14.8		15	15.1	(2.8)	14.7		12	.01	.91	-.04
													$\bar{x}$ ES =	.05

[5] Covariates: 1 = BDI gross motor raw, 2 = Family Resource Scale.

• Statistical analysis and Effect Size (ES) estimates for PSI was based on raw scores where low raw scores and positive ES are most desirable.

• A low raw score and/or a low percentile score indicates lower stress level.

• Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher percentiles and positive ESs are considered better.

• No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on all pretests collected as part of the Longitudinal Studies.

• A low raw score and/or a high percentile score indicates lower stress level, and a positive ES is more desirable.

Subgroup analysis. The interaction of duration with intensity was also analyzed using family measures data collected at Reassessment #2. As shown in Table 1.30, there were no differences found as a result of duration of early intervention. There also was no interaction effect due to the age of the children.

Table 1.30

Age at Enrollment Comparison of Family Functioning Measures Collected at Reassessment #2 for the New Orleans V.I. Intensity Study

Variable		Low Intensity			High Intensity			Group	Age Status	Groups by Age
		Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n	p Value	p Value	p Value
PSI Total	Younger	231.8	(27.4)	7	233.4	(44.0)	7	.55	.86	.61
	Older	208.3	(16.3)	8	235.8	(13.9)	4			
FSS Total	Younger	36.3	(6.4)	7	34.2	(11.2)	7	.94	.21	.54
	Older	24.2	(11.6)	8	27.0	(6.5)	4			
FRS Total	Younger	119.9	(16.9)	7	120.6	(21.7)	7	.98	.24	.89
	Older	135.3	(8.3)	8	134.2	(13.9)	4			
FACES Cohesion	Younger	36.0	(5.0)	7	42.0	(8.8)	7	.13	.91	.42
	Older	37.5	(5.4)	8	39.6	(4.3)	4			
FACES Adaptability	Younger	24.3	(6.6)	7	20.2	(5.7)	7	.21	.57	.68
	Older	20.9	(3.3)	8	18.7	(1.9)	4			

Covariates included chronological age at pretest and BDI gross motor raw score.

Parent-child interaction. The Parent/Caregiver Involvement Scale and Parent Behavior Rating Scale were used to assess differences between groups at Reassessment #2. T-tests revealed no statistically significant differences.

Table 1.31

Reassessment #2 Measures of Parent-Child Interaction for Alternative Intervention Groups for NO/VI Intensity Study

Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
Parent/Caregiver Involvement Scale								
Amount	2.9	(.4)	16	2.8	(.4)	12	.54	-.30
Quality	4.0	(.8)	16	4.1	(.5)	12	.75	.12
Appropriateness	3.9	(.9)	16	4.2	(.6)	12	.22	.34
Availability	4.3	(.9)	16	4.5	(.7)	12	.44	.21
Acceptance	4.1	(1.1)	16	4.2	(.8)	12	.62	.20
Atmosphere	4.1	(.9)	16	4.2	(.7)	12	.74	.11
Enjoyment	3.7	(1.0)	16	3.5	(.9)	12	.60	-.21
Environment	3.9	(1.1)	16	3.9	(.7)	12	.95	-.02
General Impression	4.0	(.9)	126	4.1	(.5)	12	.82	.11
Parental Behavior Rating Scale								
Affective Relationship w/child	3.1	(.7)	16	3.1	(.7)	12	.94	.03
Child Orientation	2.5	(.7)	16	3.4	(.8)	12	.96	-.14
Performance Orientation	2.9	(.6)	16	2.6	(.5)	12	.33	-.50
								$\bar{x}$ ES = .02

Reassessment #3. Results of family outcome data for a portion of the study sample are reported in Table 1.32. Data on 23 subjects are reported; one subject requested to be dropped from the study, one parent refused to complete the family measures portion of the assessment battery, and six subjects were unable to be located in time for testing.

Table 1.32

Reassessment #3 Measures of Family Functioning for Alternative Intervention Groups for NO/VI Study

		Low Intensity Group					High Intensity Group							
Variable	Covariate[δ]	$\bar{x}$	(SD)	Adj.x	%ile	n	$\bar{x}$	(SD)	Adj.x	%ile	n	ANCOVA F	p Value	ES
• **Average time between pretest and Reassessment #3 (in months)**		39.5	(3.4)			13	39.9	(1.7)			11	.11	.74	.12
• **Parent Stress Index[*] (PSI)**														
Child Related Range (50 to 235)	1	104.4	(12.4)	104.8	65	13	105.0	(21.2)	104.6	65	10	.00	.98	.02
Parent Range (47 to 270)	1	116.0	(15.7)	116.1	41	13	129.8	(20.2)	129.8	66	10	4.72	.04	-.87
• **Family Adaptation and Cohesion Evaluation Scale (FACES)**														
Adaptability	1	20.5	(4.9)	21.0		13	25.3	(7.1)	24.8		10	1.73	.20	.78
Cohesion	1	37.5	(2.8)	36.9		13	40.0	(5.5)	40.5		10	.36	.07	1.29
• **Family Resource Scale[*] (FRS)**	1	130.9	(14.9)	125.6	65	13	127.5	(18.5)	130.3	71	10	1.37	.26	.32
• **Family Support Scale[*] (FSS)**	1	27.9	(9.7)	27.7	51	13	31.1	(11.5)	31.1	63	10	.75	.40	.36
• **Family Support Scale[*] # of Sources**	1	16.7	(3.4)	16.3		13	14.0	(3.5)	14.4		10	1.46	.24	-.56
													$\bar{x}$ ES =	.19

[δ] 1 = Score for corresponding measure at pretest.

[*] A low raw score and/or a low percentile score indicates lower stress level.

[*] Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher percentiles and positive ESs are considered better.

[*] No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on all pretests collected as part of the Longitudinal Studies.

Effect Size (ES) is defined here as the difference between the groups (high intensity minus low intensity) on the $\bar{x}$ score divided by the standard deviation of the Low Intensity Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for more general discussion of the concept of Effect Size).

The results of the analyses of covariance showed that the weekly individualized intervention group scored statistically significantly higher on the parent-related stress domain of the PSI, connoting more perceived stress. The weekly individualized intervention group also scored statistically significantly higher on the cohesion subscale of the FACES III. No statistically significant differences were found between groups in regard to child-related stress, adaptability, resources, or support. The mean effect size across all reassessment #3 family measures was .19.

__Reassessment #4__. Family functioning measures of stress, adaptability, cohesion, resources, and support were collected and analyzed four years after pretest. One family refrained from completing the family measures. As shown in Table 1.33, significant differences were found only on one variable, the Family Resource Scale (p = .003) in favor of the high intensity group. Differences on all the other variables were negligible, with an average effect size of .25.

Table 1.33

Reassessment #4 Measures of Family Functioning for Alternative Intervention Groups for NO/VI Study

		Low Intensity Group					High Intensity Group							
Variable	Covariate[b]	$\bar{x}$	(SD)	Adj.x	%ile	n	$\bar{x}$	(SD)	Adj.x	%ile	n	ANCOVA F	p Value	ES
• **Average time between pretest and Reassessment #4 (in months)**		49.4	(2.8)			15	50.7	(2.8)			12	.21	.28	.39
• **Parent Stress Index• (PSI)**														
Child Related Range (50 to 235)	•	23.0	(4.0)	23.1		15	22.1	(5.2)	21.8		11	.04	.84	-.07
Parent Range (47 to 270)	•	120.8	(17.5)	117.8	43	15	127.0	(17.0)	130.0	66	11	5.25	.03	-.70
• **Family Adaptation and Cohesion Evaluation Scale (FACES)**														
Adaptability	•	23.0	(4.0)	23.1		15	22.1	(5.2)	21.8		11	.42	.53	-.25
Cohesion	•	40.5	(5.8)	39.4		15	41.2	(6.5)	38.5		11	.18	.68	-.16
• **Family Resource Scale• (FRS)**	•	124.8	(15.2)	121.1	54	15	132.5	(11.5)	136.1	82	11	11.24	.003	.99
• **Family Support Scale• (FSS)**	•	31.2	(9.6)	30.9	63	15	28.5	(11.6)	28.8	63	11	.35	.56	-.22
• **Family Support Scale• # of Sources**	•	15.7	(3.1)	15.7		15	16.4	(2.7)	16.2		11	.48	.50	-.16
													$\bar{x}$ ES =	-.08

• A low raw score and/or a low percentile score indicates lower stress level.

• Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher percentiles and positive ESs are considered better.

• No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on all pretests collected as part of the Longitudinal Studies.

Effect Size (ES) is defined here as the difference between the groups (high intensity minus low intensity) on the $\bar{x}$ score divided by the standard deviation of the Low Intensity Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for more general discussion of the concept of Effect Size).

• The corresponding pretest score was used as a covariate.

Analyses of covariance were again conducted using the corresponding pretest scores as covariates. Similar to reassessment #3, the weekly individualized intervention group scored statistically significantly higher on the parent-related subscale of the PSI, meaning that parents of the high intensity group reported more stress in this area. Statistically significant differences were also found on the FRS, with the weekly individualized intervention group reporting greater resources. No statistically significant differences were found in regard to child related stress, adaptability, cohesion, or support. The average effect size for the family measures collected at reassessment #4 was -.08.

Reassessment #5. There were 30 active subjects participating in the study as of July, 1993. Data have been collected in 26 of these 30 subjects and is reported in Table 1.34. No statistically significant differences were found on measures of support, resources, or stress. Percentile scores for the groups reveal average stress levels and above-average support and resources. No statistically significant differences were found on the Parent Self Awareness Scale or the teacher ratings of parent skill, activity, support, and knowledge. The mean effect size across all measures was -.05.

Table 1.34

Reassessment #5 Measures of Family Functioning for Alternative Intervention Groups for NO/VI Study

		Low Intensity Group					High Intensity Group							
Variable	Covariate^{b}	$\bar{x}$	(SD)	Adj.x	%ile	n	$\bar{x}$	(SD)	Adj.x	%ile	n	ANCOVA F	p Value	ES
• **Family Resource Scale**	1	132.6	(12.4)	128.6	70	16	127.0	(17.0)	127.1	67	13	.30	.59	-.12
• **Family Support Scale**	1	37.1	(12.0)	35.9	76	16	28.4	(10.6)	29.8	59	13	1.79	.19	-.51
• Parenting Stress Index (short form)														
Parent distress	1	25.0	(5.4)	25.7	55	16	26.0	(5.4)	25.3	55	13	.03	.86	.07
Parent-child dysfunction	1	21.4	(4.3)	21.5	65	16	22.0	(6.6)	21.9	65	13	.03	.86	-.09
Difficult Child Subscale	1	27.8	(7.1)	28.4	70	16	27.0	(7.5)	25.9	55	13	.75	.39	.35
• Parent Self-Awareness	2	43.6	(5.1)	43.6		16	44.8	(6.3)	44.8		13	.36	.55	.24
• Teacher Rating of Parental	2	15.9	(4.7)	15.9		14	16.2	(3.6)	16.1		9	.02	.90	.04
• Teacher Rating of Parental	2	9.6	(2.5)	9.7		14	8.9	(2.4)	8.8		9	.93	.34	-.36
														$\bar{x}$ ES = -.05

1 = FRS total pretest.

2 = Education level of the mother at pretest.

Reassessment #6. To date, data were collected for 25 of the 26 subjects who have reached reassessment #6; one parent did not complete the measures. Data on the full cohort will be completed by October, 1995. The data reported in Table 1.35 reveal statistically significant differences in family support and stress associated with parent-child dysfunction, with scores in favor of the low intensity group. No differences were found between the groups related resources, parent perception of self-awareness, or teacher perception of the parents' skills, support, or knowledge. Stress related to parent distress or difficulty of the child were slightly higher for the high intensity group, but not statistically significantly so.

Table 1.35

Reassessment #6 Measures of Family Functioning for Alternative Intervention Groups for NO/VI Study

		Low Intensity Group					High Intensity Group							
Variable	Covariate[5]	$\bar{x}$	(SD)	Adj.x	%ile	n	$\bar{x}$	(SD)	Adj.x	%ile	n	ANCOVA F	p Value	ES
• **Family Resource Scale**	1	130.8	(11.2)	128.4	68	13	127.0	(15.0)	129.3	70	12	.02	.88	.08
• **Family Support Scale**	1	37.8	(11.6)	40.0	84	12	30.6	(15.8)	28.4	51	12	3.42	.08	-1.00
• Parenting Stress Index*(short form)														
Parent distress		23.3	(6.4)		35	13	26.3	(5.9)		55	12	1.49	.23	-.47
Parent-child dysfunction	2	18.1	(4.4)	18.5	45	13	22.4	(6.2)	22.0	65	12	3.05	.10	-.180
Difficult Child Subscale	3	25.0	(5.6)	26.2	55	13	28.1	(7.9)	26.9	60	12	.09	.77	.12
• Parent Self-Awareness	4	43.3	(5.1)	43.5		13	45.6	(6.2)	45.4		12	.95	.34	.37
• Teacher Rating of Parent's Skill, Activity, Support	5	17.2	(4.4)	17.2		13	17.4	(3.1)	17.3		11	.00	.98	.02
• Teacher Rating of Parent's Knowledge	5	10.2	(2.6)	10.2		13	10.2	(1.9)	10.1		11	.01	.91	-.04
													$\bar{x}$ ES =	-.14

1 = FRS total pretest.
2 = DQ Communication Total
3 = Hours worked by mother at pretest
4 = Total Family Income at pretest
5 = Family cohesion at pretest

* High scores indicate high stress levels; negative effect size indicates the low intensity group had more desirable scores.

Conclusions

Based on the results of data collected after 12 months of intervention, it appears that the high-intensity intervention produced negligible effects on measures of child and family functioning. Child outcome measures at Reassessment #1 reflected mixed positive and negative effect sizes. Follow-up generally portrayed slight negative effect sizes.

Similarly, there appear to be no general effects on family functioning due to more intensive early intervention. Although one or two variables tend to favor the high intensity groups at one of the reassessments, there is no consistent pattern which would support findings in favor of one group or the other.

The findings of this study are substantially different than those from previous studies with children having visual impairments. Therefore, it is important to consider why these differences may have occurred.

First, this study was much more carefully controlled (e.g., randomized assignment, use of naive diagnosticians, verification of treatment implementation, use of ANCOVA). Therefore, the difference in results between this study and previous research may be attributable to the quality of the research design.

Second, perhaps the fact that intervenors were not certified in visual impairment made the high-intensity treatment less effective. This issue is worth further evaluation, but it is important to reiterate that this type of approach to providing services for children with visual impairments is consistent with what is currently practiced by most states in the country. Given that the vast majority of certified VI personnel have received training focused on school-age children and/or adults, the use of instructors certified in visual impairment who lack the early childhood and family-focused training may be equally inappropriate. The shortage of personnel with expertise in both early childhood and visual impairment is even greater than the scarcity of teachers certified to serve the visually impaired. Thus, the results of this study may be construed to support the need for specialists in the combined field of early childhood/ visual impairment. Studies comparing treatment provided by intervenors certified to serve infants and toddlers who are visually impaired versus the generic early childhood/special educator would speak to this specialized training issue.

Third, it may be that children who are visually impaired, even at this young age, need much more comprehensive intervention services. Perhaps to achieve substantial benefits it is necessary to have intervention programs which deliver professionally mediated intervention several times per week. This would obviously require greater funding than is presently available. At the same time, given the total cost of nearly $7,000 per child in agency resources, and the lack of general observable benefits for either families or children, one must consider if this funding could be spent more effectively in other ways. Such questions can only be answered definitively, however, with further well-designed comparative research.

A fourth possibility is the intervention should focus on providing primary support and assistance to the family rather than emphasize developmental therapy directed toward the child. Although Individualized Family Service Plans (IFSPs) were implemented, the intervention was primarily child-focused. Perhaps a more comprehensive orientation to the strengths and needs of the family should receive the primary emphasis, with minimal direct child contact. More intervention focused on parenting skills and coping behaviors may meet the immediate needs of parents with infants and toddlers. Again, however, carefully designed research is necessary to address this issue.

In regard to long-term effects, there do not appear to be any significant differences between the groups as measured by the aforementioned instruments. However, it would be premature to conclude that the more intensive intervention was not more beneficial for later child and/or family functioning. As other studies have shown, effects of early intervention are sometimes not evident until longitudinal data have been collected (see Infant Health and Development Program, 1990). It may be that individualized developmental intervention shows its effects in later stages (i.e., the early school years). These are issues which will require extended research.

For the present, however, the results of this research suggest that we should be careful in concluding that more intensive early intervention programs will necessarily be more cost-effective for young children with visual impairments. This study also demonstrates that carefully controlled early intervention research for such children can be done feasibly and is urgently needed. It is only by considering the results of many such studies that we will be able to determine what types of early intervention really are best for children with visual impairments and their families.

SMA/LAKE McHENRY PROJECT

Project #2

COMPARISON: Infants and Toddlers ages Birth to Three years with Severe Disabilities--Once per week versus three times per week services.

LOCAL CONTACT PERSON: Dr. Alice Kusmierek, Coordinator, Interagency Project for Early Intervention.

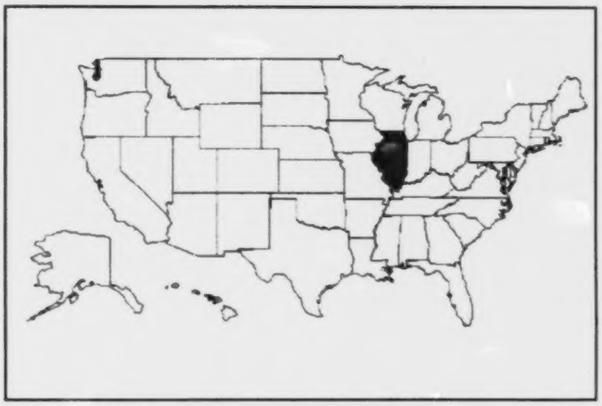
EIRI COORDINATOR: Matthew J. Taylor, Utah State University

LOCATION: Flossmoor, Illinois (Chicago Suburb)

DATE OF REPORT: October 1, 1994

Rationale for Study

Many people believe that the benefits of early intervention for participating families and children with disabilities will be substantially enhanced by increasing the number of hours in which children participate in the intervention program (Innocenti & White, 1993; White, Bush, & Casto, 1985-86). Although it may be logical to assume that there will be a positive relationship between the amount of early intervention provided to the child and the resulting benefits, there is relatively little direct evidence to support this thesis (Innocenti & White, 1993).



Additionally, even though most people believe that longer or more intensive early intervention services will be more effective, there are often objections when it is suggested that a particular early intervention program be delivered for more hours per week. Such objections usually stem from the fact that more intensive early intervention programs are more expensive. Because financial resources are usually limited, program administrators are understandably hesitant to substantially increase the hours per week of services unless there is consistent and convincing evidence that by so doing, there will be considerable benefit for participating children and their families.

If more carefully controlled research were available concerning the effects and costs of increasing the hours of early intervention delivered to a child, program administrators would be in a better position to decide how much intervention should be provided. Such questions are particularly important as programs expand to serve young children with disabilities as a result of Public Law 99-457.

Unfortunately, much of the research regarding the effects of increasing intensity of early intervention has focused only on children who were economically disadvantaged, or were medically at-risk due to premature birth. It is unclear that results of those studies can be generalized directly to children having disabilities. Of the intensity research studies published for children having disabilities, most have been with children older than 36 months of age, none have measured the effects on the family of more intensive interventions, only one included follow-up results, and most have had quite small sample sizes. Given the importance of the intensity issue and the limited available data, further research is needed. The purpose of this study was to examine the immediate and long-term effects on participating children and families of increasing the number of hours per week children participated in a systematic early intervention program.

Review of Literature

An extensive review of studies regarding the effects of enhancing the intensity of early intervention (primarily by increasing the number of hours of early intervention per month) was recently reported by Innocenti and White (1993). Table 2.1 contains a brief summary of the research done with children having disabilities.

Table 2.1

Previous Studies of Early Intervention Which Have Compared Different Intensities of Service[a]

Study	Methodological Quality[c]	Child Risk Factor	Average Group Size[d]	Age at Entry (months)	Comparison (hours/week)	Study Duration (months)	Mean Effect Size for Children[e]	Mean Effect Size for Family Members[e]
Home-visit Intervention								
Sandow, Clarke, Cox, & Stewart (1981)[b]	High	Disabled	14/14	30	0.5/0.13	26	.00	---
Jenkins et al. (1982)	High	Disabled	15/15	62	2.0/.67	4	.09	---
Law et al. (1991)	High	Disabled	35/37	57	2.75/.75	6	.00	---
Center-based Intervention								
Lovass (1987)[b]	Medium	Disabled	19/19	38	40.0/10.0	24	1.41	---
Barnett & Pezzino (1987)	High	Disabled	39/37	48	33.4/15.0	9	-.11	---
Taylor, White, & Pezzino (1984)	High	Disabled	47/47	59	32.5/16.3	9	.10	---
Jago, Jago, & Hart (1984)[b]	Low	Disabled	11/4	28	7.0/4.0	7	.15	---

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[a] Table 1 is adapted from information presented by Innocenti and White, 1993.

[b] Studies also included nonintervention or combined intervention groups. These other groups are not included in this analysis.

[c] Methodological quality is based on a rating of threats to internal validity as defined by Campbell and Stanley (1963). See Casto and White (1985) for greater detail.

[d] Group size at posttest.

[e] All effect sizes are immediately after treatment unless otherwise noted. Throughout this article, effect sizes were estimated using a standardized mean difference effect size as defined by Glass (1976); $ES = (\bar{x}_E - \bar{x}_C) \div SD_C$. A positive effect size always indicates an advantage for the more intensive group except for demographic variables where no judgment about the benefits of high or low scores are implied.

Such research is useful in setting the context for the study reported here. As can be seen in Table 2.1, most studies have not found substantial advantages associated with more intensive interventions. In fact, the only study that has reported substantial benefits for a more intensive intervention was the Lovaas (1987) study which compared 40 hours per week of one-to-one intervention to 10 hours per week of small group intervention for children diagnosed as autistic. Although the results reported by Lovaas (1987) are impressive, the study had several methodological weaknesses. Furthermore, because the results are so different from other research, it is important that replications be done to determine the robustness of these results. Additionally, it is unlikely that most early intervention programs can afford the type of intensification represented by the Lovaas study.

For the most part, the results summarized in Table 2.1 are not conclusive. More research on this important topic is necessary for several reasons. First, previous studies have defined the effects of intervention quite narrowly, have focused only on child outcomes, as opposed to family outcomes, and have usually not collected follow-up data after the intervention was completed. Second, comparative analyses of the costs of alternative intervention programs have not been done previously. Third, the intervention in most previously reported research has been of relatively short duration (nine months or less). It may be that more intensive programs have positive effects but that these effects only become evident after a year or more of intervention. Fourth, all of the studies in Table 2.1 focused on children older than three years of age. Given the widespread assumption that "earlier is better," it is not implausible that the benefits of more intensive interventions would be more apparent among children who are enrolled in intervention programs before three years of age. Finally, although most previous research summarized in Table 2.1 has been reasonably well done, there are still relatively few such studies, and there is a need for well-designed research to determine whether previous results apply to other groups of children in different settings.

As described below, the present study intervened with children under age 3, for a 24-month period, and used random assignment of subjects to groups, data collection by "blind" diagnosticians, and use of treatment verification procedures. The study goes beyond previous research by collecting extensive information about costs, as well as broader outcome data over a six-year period regarding both child and family functioning. The central research question addressed was whether the different number of hours of early intervention services between one and three hours per week would result in different benefits for participating children and families.

Methods

Subjects

A total of 72 children who were served by 3 different early intervention programs in the Chicago suburbs were included as subjects. Recruitment, assignment to groups, and demographic characteristics of the subjects are described below.

Recruitment. Subjects were recruited from three intervention programs in the Chicago suburbs. The three programs--South Metropolitan Association (SMA), Lake-McHenry Regional Program (LMRP), and Southwest Cooperative Association (SW Coop)--received funding from the State of Illinois Board of Education from July 1, 1985, through June 30, 1988, to investigate the effects on measures of child and family functioning of tripling the intensity of services that were then being provided to the birth to three population. All three programs had in the past provided once-per-week intervention services to children under age three. As a condition of receiving additional funding from the state, each agency agreed to provide three-times-per-week services to a randomly assigned experimental group, while continuing to provide once-per-week services to other children.

Between January 1, 1986, and June 30, 1987, all children who were referred to any of these three programs were considered for inclusion in the study if they were 24 months of age or less and had either a diagnosed disability or demonstrated overall developmental delay of 65% or more. A determination of developmental delay was made through a multidisciplinary team assessment conducted by the program as well as through completion of the Wisconsin Behavior Rating Scale by the member of the team assigned as the child's case manager. The age cutoff was included to ensure that all children would have an opportunity to participate in at least one year of early intervention services before moving on at age three to a preschool program operated by the public school system. Children who met the criteria were informed of the nature of the research project by program staff and asked to participate in the study. The requirement of random assignment to groups, and the possibility of obtaining three-times-per-week services, was emphasized. It was made clear that a decision not to participate in the study would in no way influence their ability to access the once-per-week services typically provided by the program.

Attrition

A total of 72 children and their families agreed to participate and were pretested in the study. Of these, approximately 23 families were not considered active by the fifth reassessment. This number was slightly higher at the sixth reassessment. However, it is expected that more families will be tested for the final reassessment. The majority of these families were lost because they moved out of the Chicago area and did not leave a forwarding address or enough information to be tracked. Several of the subject parents were either dissatisfied with the services, or felt that the testing was too intrusive to continue. Four of the subject children passed away, and one subject family was placed in a witness protection program.

Despite the high attrition in the first three years of the study, the groups remained remarkably comparable for all reassessment analyses. Those variables that did show significant differences between groups were either not practically significant (e.g., mothers' ages being three years different), or were in favor of the expanded intervention group (e.g., percent with both parents living at home, and percent with mothers employed as technical/managerial or above). In each of these cases, the differences were accounted for by covariation when a strong relationship between that variable and any dependent measure appeared. Table 2.2 shows the comparability of the groups on demographic variables for subjects used in each analysis. It should be noted that the groups were most comparable on demographics for the subjects used in the fifth reassessment. Only the percent of families using public assistance showed any significant difference, and that variable did not relate to any of the outcomes.

Table 2.3 shows the results of a series of 2 x 2 ANOVAs conducted to determine whether there were any statistically significant group by subject status (i.e., subjects who dropped versus those that did not) interactions. Differential attrition occurred for the Family Resource Scale for subjects included in reassessments 3, 4, 5, 6, and 7, the total Parenting Stress Index for subjects included in reassessment 4, the Family Support Scale for subjects included in reassessments 4, 5, and 6, and total family income for subjects included in reassessment 7. In these cases when appropriate, these variables were used as covariates to account for pretreatment differences.

One interesting note from this analysis is that there was a difference between subjects who stayed in the analyses and those that did not. As the years passed, more and more lower income subjects failed to participate in testing. This is indicated by both income and father education variables. These differences do not affect the internal validity of the study, but might add some problems for externalization.

Table 2.2

Comparability of Groups on Demographic Characteristics for SMA/Lake McHenry Project

Variable	All Subjects Pretested								Subjects Included in Year #1 Analyses (Based on Pretest Demographics)							
	Basic Intervention			Expanded Intervention					Basic Intervention			Expanded Intervention				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
Age of child in months at program entry	15.1	(6.4)	39	13.3	(6.4)	33	.24	-.28	15.0	(6.2)	31	13.7	(6.4)	29	.42	-.21
Age of mother in years	29.3	(5.8)	38	31.5	(4.9)	33	.08	.38	29.4	(5.3)	31	32.0	(5.1)	29	.06	.49
Age of father in years	31.9	(5.8)	35	33.2	(6.7)	33	.41	.22	31.7	(5.5)	28	33.7	(7.0)	29	.25	.36
Percent male	51		39	61		33	.46	.17	48		31	62		29	.11	.26
Years of education for mother	13.5	(1.9)	38	13.1	(1.6)	33	.30	-.21	13.6	(2.0)	31	13.0	(1.6)	29	.20	-.30
Years of education for father	14.1	(2.1)	35	13.6	(2.1)	33	.38	-.24	14.3	(2.0)	28	13.7	(2.1)	29	.28	-.30
Percent with both parents living at home	71		38	91		33	.05	.46	71		31	93		29	.04	.52
Percent of children who are Caucasian	82		38	97		33	.07	.42	81		31	97		29	.09	.43
Hours per week mother employed	10.6	(16.5)	38	6.9	(14.3)	32	.32	-.22	9.3	(15.5)	31	7.6	(14.9)	29	.68	-.11
Hours per week father employed	36.3	(14.3)	33	40.9	(9.8)	29	.15	.32	37.0	(14.0)	26	40.8	(10.4)	26	.27	.27
Percent of mothers employed as technical/managerial or above	11		38	25		32	.13	.36	13		31	28		29	.18	.34
Percent of fathers employed as technical/managerial or above	36		33	34		32	.87	-.04	29		26	34		28	.72	.09
Total Household income	$28,100	($21,058)	35	$29,516	($16,948)	32	.76	.07	$30,190	($22,258)	29	$29,982	($17,253)	28	.97	-.01
Percent receiving public assistance	21		33	23		26	.84	-.05	17		29	23		22	.63	-.13
Percent with mother as primary caregiver	97		33	97		30	.93	-.02	96		27	96		26	.97	-.01
Percent of children in daycare more than 5 hours per week	10		39	3		33	.34	-.22	13		24	3		22	.66	-.21
Number of siblings	1.1	(1.1)	38	1.2	(1.0)	33	.70	.09	.9	(.8)	31	1.2	(1.0)	29	.20	.38
Percent with English as primary language	92		38	100		33	.22	.29	90		31	100		29	.19	.33

(continued)

NOTE: Effect sizes from percentages were computed from a t statistic after an additional subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

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Table 2.2 (continued)

Comparability of Groups on Demographic Characteristics for SMA/Lake McHenry Project

	Subjects Included in Year #2 Analyses (Based on Pretest Demographics)								Subjects Included in Year #3 Analyses (Based on Pretest Demographics)							
	Basic Intervention			Expanded Intervention					Basic Intervention			Expanded Intervention				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
Age of child in months at program entry	15.0	(6.4)	28	12.5	(5.6)	21	.16	-.39	15.8	(6.3)	22	12.4	(5.6)	16	.19	-.54
Age of mother in years	28.9	(5.3)	28	32.2	(5.2)	21	.03	.62	29.9	(5.4)	22	31.6	(4.8)	16	.32	.31
Age of father in years	31.2	(5.6)	25	33.2	(5.6)	21	.22	.36	31.3	(5.0)	21	32.7	(5.0)	16	.42	.28
Percent male	50		28	62		21	.45	.22	45		22	62		16	.34	.30
Years of education for mother	13.7	(2.1)	28	13.2	(1.7)	21	.39	-.24	13.7	(2.1)	22	13.5	(1.8)	16	.73	-.10
Years of education for father	14.4	(2.0)	25	14.1	(2.2)	21	.62	-.15	14.5	(2.0)	21	14.7	(2.2)	16	.76	.14
Percent with both parents living at home	71		28	90		21	.15	.41	86		22	94		16	.63	.16
Percent of children who are Caucasian	82		28	95		21	.26	.31	86		22	94		16	.63	.16
Hours per week mother employed	9.0	(15.4)	28	7.2	(14.4)	21	.68	-.12	8.9	(13.4)	22	8.6	(16.1)	16	.95	-.02
Hours per week father employed	38.3	(12.6)	23	40.5	(11.5)	18	.57	.17	40.1	(10.1)	20	40.6	(12.7)	15	.89	.05
Percent of mothers employed as technical/managerial or above	11		28	29		21	.13	.42	9		22	38		16	.05	.64
Percent of fathers employed as technical/managerial or above	25		28	38		21	.35	.26	27		22	52		16	.17	.43
Total Household income	$30,481	($23,251)	26	$32,775	($18,448)	20	.72	.10	$34,524	($33,250)	21	$34,700	($20,158)	15	.98	.01
Percent receiving public assistance	15		27	19		16	.68	-.12	5		21	8		12	.61	-.18
Percent with mother as primary caregiver	96		25	95		19	.79	-.08	95		20	93		14	.74	-.11
Percent of children in daycare more than 5 hours per week	11		28	05		21	.61	-.14	14		22	6		16	.63	-.16
Number of siblings	.9	(.7)	28	1.2	(.9)	21	.23	.45	.9	(.8)	22	.9	(.9)	16	.91	.00
Percent with English as primary language	89		28	100		21	.28	.31	91		22	100		16	.47	.23

(continued)

NOTE: Effect sizes from percentages were computed from a t statistic after an additional subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

Table 2.2 (continued)

Comparability of Groups on Demographic Characteristics for SMA/Lake McHenry Project

	Subjects Included in Year #4 Analyses (Based on Pretest Demographics)								Subjects Included in Year #5 Analyses (Based on Pretest Demographics)							
	Basic Intervention			Expanded Intervention					Basic Intervention			Expanded Intervention				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES
Age of child in months at program entry	15.0	(6.1	20	12.9	(5.9)	18	.30	-.34	15.4	(5.9)	24	13.4	(6.2)	25	.24	-.34
Age of mother in years	28.8	(5.0)	20	31.9	(4.4)	18	.05	.62	29.3	(5.5)	24	32.4	(5.0)	25	.05	.56
Age of father in years	30.7	(5.1)	19	33.1	(4.6)	18	.13	.47	31.2	(5.3)	23	34.4	(7.0)	25	.08	.60
Percent male	35		20	67		18	.06	.58	38		24	56		25	.22	.34
Years of education for mother	13.7	(1.9)	20	13.3	(1.7)	18	.60	-.21	13.6	(2.0)	24	13.2	(1.7)	25	.42	-.20
Years of education for father	14.2	(2.0)	20	14.4	(2.2)	18	.72	.10	14.2	(2.0)	24	14.0	(2.1)	25	.73	-.10
Percent with both parents living at home	85		20	89		18	.79	.08	83		24	92		25	.42	.22
Percent of children who are Caucasian	95		19	94		18	.96	-.02	87		23	96		25	.34	.27
Hours per week mother employed	7.8	(11.9)	20	7.7	(15.3)	18	.98	-.01	8.0	(12.5)	24	7.0	(13.9)	25	.81	-.08
Hours per week father employed	40.1	(10.4)	19	40.2	(12.6)	15	.97	.01	38.3	(12.6)	23	40.4	(11.0)	22	.55	.17
Percent of mothers employed as technical/managerial or above	5		20	33		18	.04	.65	8		24	28		25	.10	.45
Percent of fathers employed as technical/managerial or above	33		18	47		17	.45	.25	36		22	38		24	.94	.02
Total Household Income	$33,611	($22,775)	18	$32,676	($19,702)	17	.90	-.04	$32,727	($20,833)	22	$30,688	($17,936)	24	.72	-.10
Percent receiving public assistance	5		20	20		15	.22	-.40	5		22	26		19	.08	.54
Percent with mother as primary caregiver	94		18	94		16	.91	-.04	95		21	96		23	.93	.02
Percent of children in daycare more than 5 hours per week	15		20	6		18	.47	-.23	17		24	4		25	.21	-.35
Number of siblings	1.0	(0.8)	20	1.1	(0.9)	18	.69	.13	.9	(.8)	24	1.2	(1.0)	25	.22	.38
Percent with English as primary language	90		20	100		18	.36	.29	92		24	100		25	.29	.29

NOTE: Effect sizes from percentages were computed from a t statistic after an additional subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

Table 2.2 (continued)

Comparability of Groups on Demographic Characteristics for SMA/Lake McHenry Project

	Subjects included in Year #6 Analyses							
	Basic Intervention			Expanded Intervention			p	
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	Value	ES^
Age of child in months at program entry	15.1	(6.4)	19	12.6	(5.6)	23	.18	-.39
Age of mother in years	30.2	(5.8)	19	31.3	(4.4)	23	.48	.19
Age of father in years	32.3	(5.2)	18	33.5	(6.7)	23	.52	.23
Percent male	47		19	61		23	.42	.24
Years of education for mother	14.1	(1.7)	19	13.1	(1.7)	23	.08	-.59
Years of education for father	14.6	(2.0)	19	14.1	(2.2)	23	.41	-.25
Percent with both parents living at home	89		19	91		23	.82	.07
Percent of children who are Caucasian	94		18	96		23	.82	.07
Hours per week mother employed	6.9	(11.1)	19	7.3	(14.9)	23	.92	.04
Hours per week father employed	40.1	(10.4)	19	43.1	(6.9)	20	.30	.29
Percent of mothers employed as technical/managerial or above	11		19	30		23	.16	.42
Percent of fathers employed as technical/managerial or above	47		17	41		22	.72	-.11
Total Household income	$34,763	($21,427)	19	$30,636	($18,284)	22	.51	-.19
Percent receiving public assistance	6		18	29		17	.10	.54
Percent with mother as primary caregiver	94		18	100		20	.51	.21
Percent of children in daycare more than 5 hours per week	21		19	4		23	.14	-.44
Number of siblings	1.0	(.8)	19	1.2	(1.0)	23	.55	.25
Percent with English as primary language	95		19	100		23	.47	.22

NOTE: Effect sizes from percentages were computed from a t statistic after an additional subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

Table 2.2 (continued)

Comparability of Groups on Demographic Characteristics for SMA/Lake McHenry Project

	Subjects included in Year #7 Analyses							
	Basic Intervention			Expanded Intervention			p	
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	Value	ES^
Age of child in months at program entry	15.9	(6.7)	12	12.0	(5.7)	15	.11	-.58
Age of mothers in years	31.2	(5.9)	12	31.4	(5.0)	15	.92	.03
Age of father in years	32.8	(4.8)	12	33.7	(7.8)	15	.73	.19
Percent male	58		12	53		15	.82	-.08
Years of education for mother	14.5	(1.7)	12	13.1	(1.9)	15	.05	-.82
Years of education for father	15.1	(1.8)	12	14.0	(2.2)	15	.19	-.61
Percent with both parents living at home	100		12	93		15	.68	-.15
Percent of children who are Caucasian	100		12	93		15	.68	-.15
Hours per week mother employed	6.3	(11.4)	12	4.5	(11.7)	15	.68	-.16
Hours per week father employed	42.2	(4.0)	12	42.6	(7.3)	14	.87	.10
Percent of mothers employed as technical/managerial or above	8		12	33		15	.19	.48
Percent of fathers employed as technical/managerial or above	60		10	36		14	.29	-.41
Total Household income	$40,042	($26,609)	12	$30,400	($16,931)	15	.22	-.36
Percent receiving public assistance	0		11	30		10	.11	.65
Percent with mother as primary caregiver	100		12	100		14	.92	.03
Percent of children in daycare more than 5 hours per week	17		12	0		15	.21	-.46
Number of siblings	1.1	(.8)	12	1.2	(1.0)	15	.74	.13
Percent with English as primary language	100		12	100		15	.89	.05

NOTE: Effect sizes from percentages were computed from a *t* statistic after an additional subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

Table 2.3
Attrition Data for the SMA/Lake McHenry Intensity Study

		Low Intensity			High Intensity			ANOVA					
								Group		Study Status		Group by Status	
Variable		$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	F	p	F	p	F	p
Reassessment #1													
CA at pretest	IN	15.0	(6.2)	31	13.7	(6.4)	29	2.08	.15	0.28	.60	0.69	.41
	OUT	15.6	(7.5)	8	10.8	(6.6)	4						
BDI DQ[*]	IN	52.3	(27.5)	31	60.8	(26.0)	29	0.01	.92	0.30	.58	0.69	.41
	OUT	64.9	(32.2)	8	58.2	(26.1)	4						
Total PSI[**]	IN	248.3	(44.0)	31	235.9	(43.9)	29	0.23	.63	0.88	.35	0.16	.70
	OUT	229.5	(34.2)	8	228.3	(27.0)	4						
FRS	IN	120.1	(25.7)	29	118.0	(15.7)	27	0.81	.37	0.05	.82	1.39	.24
	OUT	112.9	(18.9)	8	128.7	(3.2)	3						
FSS	IN	30.5	(12.9)	30	27.7	(9.4)	29	0.65	.42	0.01	.92	2.37	.13
	OUT	25.0	(8.8)	7	34.0	(15.3)	4						
Mother Education	IN	13.6	(2.0)	31	13.0	(1.6)	29	0.01	.93	0.01	.93	0.82	.37
	OUT	13.0	(1.5)	7	13.5	(1.7)	4						
Father Education	IN	14.3	(2.0)	28	13.7	(2.1)	29	0.27	.61	1.64	.21	0.10	.75
	OUT	13.1	(2.3)	7	13.0	(2.4)	4						
Income	IN	$30,190	($22,258)	29	$29,982	($17,253)	28	0.36	.55	1.41	.24	0.40	.53
	OUT	$18,000	($9,649)	6	$26,250	($16,520)	4						
Percent Male	IN	48.0		31	62.0		29	0.00	.97	0.00	.95	0.60	.44
	OUT	63.0		8	50.0		4						
Reassessment #2													
CA at Pretest	IN	15.0	(6.4)	28	12.5	(5.6)	21	0.95	.33	0.72	.40	0.30	.59
	OUT	15.5	(6.9)	11	14.8	(7.5)	12						
BDI DQ[*]	IN	50.8	(28.4)	28	61.1	(25.2)	21	0.09	.76	0.86	.36	1.43	.24
	OUT	65.4	(27.5)	11	59.3	(27.3)	12						
Total PSI[**]	IN	246.8	(45.5)	28	243.0	(41.2)	21	0.98	.33	2.00	.16	0.40	.53
	OUT	238.5	(34.5)	11	221.1	(41.2)	12						
FRS	IN	120.5	(26.7)	26	116.9	(16.9)	21	0.35	.56	0.00	.95	1.52	.22
	OUT	113.9	(17.7)	11	124.1	(9.3)	9						
FSS	IN	29.3	(12.5)	27	26.9	(9.1)	21	0.04	.85	0.73	.40	0.38	.54
	OUT	30.0	(12.3)	10	31.3	(11.7)	12						
Mother Education	IN	13.7	(2.1)	28	13.2	(1.7)	21	0.45	.50	1.97	.17	0.12	.73
	OUT	12.9	(1.4)	10	12.8	(1.6)	12						
Father Education	IN	14.4	(2.0)	25	14.1	(2.2)	21	0.50	.48	5.72	.02	0.02	.89
	OUT	13.2	(2.2)	10	12.8	(1.7)	12						
Income	IN	$30,481	($23,251)	26	$32,775	($18,448)	20	0.26	.61	3.14	.08	0.00	.96
	OUT	$21,222	($11,111)	9	$24,083	($13,045)	12						
Percent Male	IN	50.0		28	62.0		21	0.37	.55	0.00	.97	0.10	.75
	OUT	55.0		11	58.0		12						
Reassessment #3													
CA at pretest	IN	15.8	(6.3)	22	12.4	(5.6)	16	1.27	.26	0.00	.99	1.18	.28
	OUT	14.2	(6.6)	17	14.1	(7.0)	17						
BDI DQ[*]	IN	55.0	(26.2)	22	61.1	(27.7)	16	0.72	.40	0.01	.91	0.01	.94
	OUT	54.8	(32.2)	17	59.8	(24.3)	17						
Total PSI[**]	IN	242.0	(48.3)	22	243.3	(46.8)	16	0.90	.35	0.27	.60	1.16	.29
	OUT	247.6	(34.6)	17	227.2	(36.4)	17						
FRS	IN	123.8	(27.3)	20	115.7	(17.0)	16	0.06	.81	0.18	.67	3.43	.07
	OUT	112.3	(19.2)	17	122.9	(12.4)	14						
FSS	IN	29.6	(10.7)	21	27.6	(9.2)	16	0.13	.72	0.06	.81	0.13	.72
	OUT	29.3	(14.5)	16	29.3	(11.2)	17						
Mother Education	IN	13.7	(2.1)	22	13.5	(1.8)	16	0.80	.37	2.64	.11	0.13	.72
	OUT	13.2	(1.7)	16	12.6	(1.4)	17						
Father Education	IN	14.5	(2.0)	21	14.7	(2.2)	16	0.43	.52	10.71	.00	1.20	.28
	OUT	13.4	(2.2)	14	12.6	(1.5)	17						
Income	IN	$34,524	($23,249)	21	$34,700	($20,158)	15	0.54	.47	8.16	.01	0.49	.49
	OUT	$18,464	($12,707)	14	$24,941	($12,392)	17						
Percent Male	IN	46.0		22	63.0		16	0.50	.48	0.16	.69	0.50	.48
	OUT	59.0		17	59.0		17						

[*] Developmental quotients were computed by dividing the age equivalent scores by chronological age

[**] Lower scores on the Parent Stress Index are considered better.

(continued)

Table 2.3 (continued)
Attrition Data for the SMA/Lake McHenry Intensity Study

		Low Intensity			High Intensity			ANOVA					
								Group		Study Status		Group by Status	
Variable		x̄	(SD)	n	x̄	(SD)	n	F	p	F	p	F	p
Reassessment #4													
CA at Pretest	IN	15.0	(6.1)	20	12.9	(5.9)	18	1.32	.25	0.11	.75	0.04	.85
	OUT	15.2	(7.0)	19	13.7	(7.0)	15						
BDI DQ*	IN	58.1	(23.8)	20	62.7	(26.3)	18	0.69	.41	0.80	.37	0.02	.90
	OUT	51.5	(33.2)	19	57.7	(25.3)	15						
Total PSI**	IN	228.0	(33.7)	20	244.3	(44.3)	18	1.28	.26	0.49	.49	8.12	.01
	OUT	261.8	(44.5)	19	223.8	(37.3)	15						
FRS	IN	126.4	(22.6)	18	115.5	(16.1)	18	0.06	.81	0.44	.51	5.95	.02
	OUT	111.0	(24.0)	19	124.3	(12.6)	12						
FSS	IN	33.1	(11.5)	19	27.5	(8.9)	18	0.09	.77	0.93	.34	3.15	.08
	OUT	25.7	(12.2)	18	29.7	(11.7)	15						
Mother Education	IN	13.7	(1.9)	20	13.3	(1.7)	18	1.13	.29	1.13	.29	0.11	.74
	OUT	13.3	(2.0)	18	12.7	(1.5)	15						
Father Education	IN	14.2	(2.0)	20	14.4	(2.2)	18	1.06	.31	4.83	.03	2.33	.13
	OUT	13.8	(2.2)	16	12.6	(1.5)	16						
Income	IN	$33,611	($22,775)	18	$32,676	($19,702)	17	0.09	.77	3.82	.06	0.25	.62
	OUT	$22,265	($17,910)	17	$25,933	($12,905)	15						
Percent Male	IN	35.0		20	67.0		18	0.51	.48	0.74	.39	4.03	.05
	OUT	68.0		19	53.0		15						
Reassessment #5													
CA at pretest	IN	15.4	(5.9)	24	13.4	(6.2)	25	1.09	.30	0.10	.76	0.03	.86
	OUT	14.6	(7.4)	15	13.1	(7.3)	8						
BDI DQ*	IN	57.5	(23.8)	24	61.3	(26.6)	25	0.57	.45	0.52	.47	0.05	.82
	OUT	50.7	(35.4)	15	57.8	(23.7)	8						
Total PSI**	IN	235.5	(37.9)	24	234.4	(45.7)	25	1.09	.30	1.36	.25	0.89	.35
	OUT	258.7	(46.6)	15	236.9	(29.8)	8						
FRS	IN	126.4	(20.9)	22	117.5	(16.8)	23	0.59	.44	1.42	.24	5.92	.02
	OUT	106.9	(24.9)	15	124.1	(6.7)	7						
FSS	IN	34.0	(11.7)	23	28.9	8.6)	25	0.00	.99	5.79	.02	3.34	.07
	OUT	22.1	(9.6)	14	27.3	(14.7)	8						
Mother Education	IN	13.6	(2.0)	24	13.2	(1.7)	25	1.29	.26	0.91	.34	0.06	.81
	OUT	13.3	(1.9)	14	12.6	(1.5)	8						
Father Education	IN	14.2	(2.0)	24	14.0	(2.1)	25	1.80	.19	2.53	.12	0.96	.33
	OUT	13.8	(2.3)	11	12.5	(1.7)	8						
Income	IN	$32,727	($20,833)	22	$30,683	($17,936)	24	0.13	.72	2.84	.10	0.58	.45
	OUT	$20,269	($19,778)	13	$26,000	($14,008)	8						
Percent Male	IN	38		24	56		25	0.62	.43	4.61	.04	0.43	.51
	OUT	73		15	75		8						
REASSESSMENT #6													
CA at pretest	IN	15.1	(6.4)	19	12.6	(5.6)	23	.71	.40	.51	.48	.52	.48
	OUT	15.1	(6.6)	20	14.9	(8.0)	10						
BDI DQ*	IN	54.0	(23.8)	19	59.0	(27.5)	23	.90	.35	.21	.65	.05	.83
	OUT	55.7	(33.0)	20	63.7	(21.5)	10						
Total PSI**	IN	242.9	(32.9)	19	239.7	(44.9)	23	1.39	.24	.36	.55	.76	.39
	OUT	245.9	(50.7)	20	224.2	(33.9)	10						
FRS	IN	132.4	(12.6)	19	115.3	(15.8)	21	.56	.46	3.09	.08	20.29	.00
	OUT	103.9	(25.3)	18	127.8	(9.7)	9						
FSS	IN	35.9	(11.4)	19	28.6	(8.9)	23	.12	.73	6.78	.01	5.99	.02
	OUT	22.7	(9.4)	18	28.2	(13.2)	10						
Mother Education	IN	14.1	(1.7)	19	13.1	(1.7)	23	1.21	.28	2.67	.11	1.24	.27
	OUT	12.9	(2.0)	19	12.9	(1.4)	10						
Father Education	IN	14.6	(2.0)	19	14.1	(2.2)	23	1.91	.17	7.68	.01	.10	.75
	OUT	13.4	(2.1)	16	12.5	(1.5)	10						
Income	IN	$34,763	($21,427)	19	$30,636	($18,284)	22	.08	.78	3.62	.06	1.32	.25
	OUT	$20,188	($18,197)	16	$27,050	($14,125)	10						
Percent Male	IN	47		19	61		23	.54	.47	.07	.79	.11	.74
	OUT	55		20	60		10						

(continued)

* Developmental quotients were computed by dividing the age equivalent scores by chronological age
** Lower scores on the Parent Stress Index are considered better.

Table 2.3 (continued)
Attrition Data for the SMA/Lake McHenry Intensity Study

		Low Intensity			High Intensity			ANOVA					
								Group		Study Status		Group by Status	
Variable		$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	F	p	F	p	F	p
Reassessment #7													
CA at Pretest	IN	15.9	(6.7)	12	12.0	(5.7)	15	1.82	.18	.15	.70	1.27	.26
	OUT	14.7	(6.4)	27	14.4	(6.8)	18						
BDI DQ	IN	47.0	(26.2)	12	51.9	(27.1)	15	1.13	.29	4.20	.04	.11	.75
	OUT	58.4	(29.3)	27	67.6	(22.6)	18						
Total PSI	IN	248.6	(32.0)	12	237.3	(45.1)	15	.98	.33	.23	.63	.01	.93
	OUT	242.6	(46.8)	27	233.1	(40.4)	18						
FRS	IN	133.6	(10.9)	12	118.9	(17.6)	13	.47	.49	4.96	.03	5.13	.03
	OUT	111.3	(25.8)	25	119.1	(13.8)	17						
FSS	IN	34.0	(8.1)	12	28.4	(9.8)	15	.61	.44	1.37	.25	1.50	.23
	OUT	27.3	(13.5)	25	28.6	(10.7)	18						
Mother Educaiton	IN	14.5	(1.7)	12	13.1	(1.9)	15	2.68	.11	2.89	.09	2.81	.10
	OUT	13.0	(1.9)	26	13.1	(1.4)	18						
Father Education	IN	15.1	(1.8)	12	14.0	(2.2)	15	1.69	.20	5.00	.03	.67	.41
	OUT	13.5	(2.1)	23	13.3	(2.0)	18						
Income	IN	$40,042	($22,609)	12	$30,400	($16,931)	15	.09	.77	4.60	.04	3.19	.08
	OUT	$21,870	($17,645)	23	$28,735	($17,446)	17						
Percent Male	IN	58		12	53		15	.29	.59	.02	.90	.89	.35
	OUT	48		27	67		18						

Assignment to groups. Subjects entered the study on a continuous basis as identified by the programs and were randomly assigned to groups by the EIRI coordinator. Data on the subject's disability and/or developmental status as provided by the program, and parent's level of stress as determined by the parent's score on the Parenting Stress Index (PSI) (Abidin, 1986) were used to stratify the subjects prior to random assignment. (A more detailed description of the procedures utilized to randomly assign subjects can be found in the Base Period Report.)

Demographic characteristics. Data on the demographic characteristics of all subjects enrolled in the study, as well as subjects in the experimental and control groups who participated in reassessments 1 through 7, are presented in Table 2.2. The total sample can be characterized as predominantly Caucasian and middle class. Most subjects lived in two-parent households in which fathers were employed full time and mothers were the primary caretakers for the child.

Intervention Programs

The two intervention groups received very similar types of service, but differed with regard to the frequency with which those services were provided, with the experimental group receiving three-times-per-week services and the comparison group receiving once-per-week services. The specific services provided are described below.

Basic intervention (once-per-week services). Children and primary caretakers in this group participated in a once-per-week contact with either an infant specialist (e.g., speech/language pathologist or occupational or physical therapist) or an early childhood special educator. While most contacts occurred at a center-based location, programs did allow the flexibility of conducting some of the contacts in the parent's home. Since the programs did not provide transportation to the children and their parents, the most common reason for providing a home visit was lack of transportation to the center. However, home visits were also provided when a particular teaching session could be most effectively accomplished in the home (e.g., when feeding or sleeping behaviors were of concern).

The content of the intervention sessions was directly related to the needs of the specific child and family as specified in the child's Individualized Education Plan (IEP). No specific curriculum was followed unless the individual specialist or educator found that doing so would be particularly advantageous in meeting the child and family's specific needs. Thus, the specialists and educators had the freedom of determining the activities to be done during the individual sessions. In general, there was a program expectation that the sessions would focus on improving child development in the domains of personal/social, adaptive, motor, language, and cognitive functioning, and that the sessions would also help parents to become intervenors for their child.

A major goal of the sessions was to provide a forum for parents to discuss issues of concern to them and to help them adapt to daily demands of caring for a child with a disability. During the first year, funding from the Illinois State Board of Education allowed the programs to hold a number of inservices to provide staff with additional training in providing family-focused intervention services (e.g., Dunst, Trivette, & Deal, 1988). This training emphasized the importance of addressing parent-identified needs as well as strengths in an effort to empower parents to become capable of dealing with the demands of caring for a child with special needs rather than relying solely on professional helpers and helping systems.

Expanded intervention (three-times-per-week services). Children who were assigned to this group participated in three, one-hour contacts per week with a specialist or educator. The content and focus of the sessions were the same as that for the comparison group. The increased staff contact time allowed for a wider range of IEP goals to be addressed, and the more frequent contact allowed more parent concerns and issues to be incorporated into the treatment sessions.

Treatment verification. A number of procedures were used to verify that treatment was implemented as intended. First, attendance data and parent ratings of satisfaction with the program were examined. The three-day-per-week group received 2½ times as many sessions as the basic group. Table 2.4 shows that this ratio held up for both years. In addition, the expanded group subjects were offered more than 2½ sessions per week in both years. It seems likely that the lower attendance rates observed are typical when more service hours are offered over time. Despite the statistical significance between attendance rates, and the lower than prescribed ratio of services, it seems clear from this data that the treatment was implemented as planned and that these figures represent the kind of attendance service deliverers should expect at these two levels of intensity.

Table 2.4

Treatment Verification for SMA/Lake-McHenry Project for Year #1 and #2 Reassessments

Variable	Basic Intervention			Expanded Intervention			ANOVA F	p Value	ES
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n			
Reassessment #1									
Parent Rating of Satisfaction[^]	24.2	(4.2)	31	23.7	(3.2)	29	0.31	.58	-.12
Rating of Intervention[+]									
Quality of Session	19.9	(8.1)	29	16.1	(7.3)	26	3.20	.08	-.47
Ranking of Intervenor	1.1	(.4)	28	1.2	(.4)	26	0.24	.63	.25
Total # of Sessions Attended	26.9	(6.8)	31	63.7	(16.4)	29	132.60	.00	5.41
Total # of Sessions Offered	36.3	(4.8)	31	95.9	(13.5)	29	534.80	.00	12.42
Percent Attendance	74.1	(16.5)	31	66.8	(14.8)	29	3.25	.08	-.44
Reassessment #2									
Parent Rating of Satisfaction[^]	24.3	(2.6)	27	24.9	(2.5)	21	0.50	.48	.23
Total # of Sessions Attended	15.0	(7.8)	23	37.8	(24.2)	20	18.23	.00	2.92
Total # of Sessions Offered	19.9	(11.1)	23	53.4	(31.6)	20	22.75	.00	3.02
Percent Attendance	78.7	(14.4)	23	68.4	(19.1)	20	3.27	.08	-.64

[+] Videotapes of a typical intervention session were scored by independent raters as to how well best practices were followed. Highest possible rating was 32.

[^] Parents rated their satisfaction with the program in 7 areas on a scale of 1 = poor, 2 = fair, 3 = good, and 4 = excellent.

Parents were also asked to rate their satisfaction with services on a 4-point scale in 7 areas. Results indicate that parents of subjects in each group were equally satisfied in both Year 1 and Year 2.

At the first reassessment, videotapes of a typical treatment session were also rated to determine the extent to which the intervention represented 'best practices.' The highest possible rating was 32. The results of group comparisons on these variables are contained in Table 2.4. The quality of intervention was ranked slightly higher for the comparison group. There was no statistically significant difference in the ranking of intervenors by their supervisors, or in the parents' satisfaction with services. Thus, the results obtained from the video rating seem to be a product of random fluctuation and the typically lower reliability associated with rating scales.

Contextual variables. In addition to the attendance and parent satisfaction data, variables describing the context of the intervention for both groups were collected each year and are reported in Table 2.5. These contextual variables are presented in 5 sections for all reassessments except Year 3. Teacher rating of parents were not measured for reassessment 3. As can be seen for the complete reassessments, only two variables other than the teacher rating of parents were statistically significantly different across groups. These variables were the amount of speech therapy received during Year 2 and negative life events at Year 6. Two statistically significant variable is less than one would expect from simple random chance for the many variables reported in this table. Therefore, it seems that these groups had an almost identical history of context for all the complete reassessments in this study. The group context for the seventh reassessment shows differences in annual income and support from parents; however, these differences may not remain when testing is complete.

The differential results indicated by the teacher rating of parents shows that the parents of subjects in the expanded group demonstrated more support for the program in Year 1 and had more knowledge appropriate for the benefit of their child in Years 1 and 2. This would be another indication that the treatment was delivered as planned. Overall, the contextual variables show how comparable the groups' experiences have been outside of treatment over the course of this study.

Cost of alternative interventions. Program costs were calculated using the ingredients approach (Levin, 1983). The ingredients approach is a systematic, well-tested procedure for identifying all of the social costs for implementing alternative programs, including costs that are often omitted from cost analysis such as

Table 2.5

Comparison of Contextual Variables for Basic and Expanded Intervention Groups for SMA/Lake McHenry

	Basic Intervention			Expanded Intervention				
	x̄	(SD)	n	x̄	(SD)	n	p Value	ES
Reassessment #1								
• **Child Health**	2.0	(0.5)	31	1.8	(0.5)	29	.32	-.40
• **Demographics**								
Percent child living with both parents	79		29	93		29	.17	.35
Mothers' employment hrs/week	10.0	(18.4)	30	11.4	(17.1)	27	.77	.08
Annual Income	$29,661	($22,310)	31	$31,333	($19,497)	27	.76	.07
• **Family Variables**								
Family Resources (FRS)	119.0	(23.8)	31	121.0	(15.1)	29	.71	.08
Family Life Events (FILE)	10.3	(6.2)	31	[illegible]	(6.6)	29	.63	-.13
• **Teacher Rating of Parents'**								
Attendance	2.5	(0.7)	31	2.6	(0.6)	29	.66	.14
Support	2.4	(0.7)	31	2.8	(0.4)	29	.03	.57
Knowledge	2.1	(0.7)	31	2.5	(0.6)	29	.03	.57
• **Additional Services (% Received)**								
> 5 hours/week daycare	19		31	24		29	.67	.11
Speech Therapy	16		31	21		29	.67	.11
Physical or Occupational Therapy	32		31	21		29	.35	-.24
Social Work Services	0		31	7		29	.28	.27
Home Nursing Services	7		31	17		29	.24	.29
Nutritional Services	3		31	10		29	.36	.29
Respite Services	10		31	3		29	.45	-.19
Parent Services	23		31	17		29	.65	-.12
Reassessment #2								
• **Child Health**	1.9	(0.4)	27	1.9	(0.5)	21	.81	.00
• **Demographics**								
Percent child living with both parents	70		27	86		21	.27	.31
Mothers' employment hrs/week	9.5	(17.2)	28	9.8	(13.7)	21	.95	.02
Annual Income	$33,107	($24,273)	28	$40,588	($27,436)	18	.34	.31
• **Family Variables**								
Family Resources (FRS)	119.0	(18.2)	28	120.1	(19.2)	21	.83	.06
Family Life Events (FILE)	9.6	(7.2)	28	10.8	(5.9)	20	.55	-.17
• **Teacher Rating of Parents'**								
Attendance	2.6	(0.8)	12	2.8	(0.6)	14	.46	.25
Support	2.6	(0.5)	12	2.7	(0.6)	14	.56	.20
Knowledge	2.5	(0.7)	12	2.9	(0.3)	14	.04	.57
• **Additional Services (% Received)**								
> 5 hours/week daycare	21		28	22		18	.89	.04
Speech Therapy	27		26	63		19	.02	.70
Physical or Occupational Therapy	50		26	58		19	.63	.14
Social Work Services	8		26	0		19	.47	-.21
Respite Services	15		26	37		19	.11	.46

Data are based on teacher rating of parents' attendance, support, and knowledge range (1-3). Higher scores indicate better ratings.

Analyses for the FRS are based on raw scores indicating number of supports on resources indicated by the family as being available. Higher scores and positive ESs are considered better. Analyses for the FILE are based on raw scores. Lower scores represent less stress and are considered better.

Annually, parents completed an additional services form which described other types of intervention or additional services the child and family received.

Based on parent rating of the child's health where 1 = worse than peers, 2 = same as peers, 3 = better than peers

NOTE: ESs from percentages were computed from a t statistic after a subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

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Table 2.5 (continued)

	Basic Intervention			Expanded Intervention				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
Reassessment #3								
• **Child Health**	2.0	(0.6)	22	1.9	(0.6)	17	.94	-.17
• **Demographics**								
Percent child living with both parents	77		22	82		17	.77	.09
Mothers' employment hrs/week	10.4	(16.8)	21	12.8	(15.3)	17	.65	.14
Annual Income	$41,659	($23,260)	22	$49,000	($26,268)	15	.38	.32
• **Family Variables**								
Family Resources (FRS)[*]	121.4	(17.2)	22	118.9	(14.4)	15	.65	.15
Family Life Events (FILE)[*]	9.8	(7.6)	22	10.5	(7.5)	15	.78	-.09
• **Additional Services (% Received)**[*]								
Speech Therapy	26		23	24		17	.90	.04
Physical or Occupational Therapy	35		23	24		17	.51	.20
Social Work Services	4		23	0		17	.73	.11
Respite Services	18		22	35		17	.25	-.35
Reassessment #4								
• **Child Health**	2.0	(0.3)	18	1.9	(0.6)	16	.47	-.33
• **Demographics**								
Percent child living with both parents	76		17	88		16	.50	.23
Mother's employment hrs/week	11.7	(14.8)	17	15.2	(18.7)	13	.58	.24
Annual Income	$42,618	($20,862)	17	$47,333	($27,734)	15	.59	.23
• **Family Variables**								
Family Resources (FRS)[*]	120.3	(16.4)	14	118.9	(17.0	14	.83	-.09
Family Life Events (FILE)[*]	9.1	(5.6)	17	8.6	(7.6)	16	.83	.09
• **Teacher Rating of Parents**[$]								
Attendance	2.6	(0.5)	9	2.3	(0.8)	6	.53	-.60
Knowledge	2.7	(0.5)	9	2.3	(0.8)	6	.34	-.80
• **Additional Services (% Received)**[*]								
≥ 5 hours/week daycare	25		20	33		18	.61	-.16
Speech Therapy	59		17	44		16	.87	.05
Physical or Occupational Therapy	59		17	50		16	.65	.15
Social Work Services	6		17	0		16	.60	.18
Respite Services	6		17	19		16	.35	-.31
Reassessment #5								
• **Child Health**	2.0	(0.5)	23	1.9	(0.6)	25	.43	-.20
• **Demographics**								
Percent child living with both parents	0.9	(0.3)	21	100		22	.29	.32
Annual Income	$36,478	($18,273)	23	$40,190	($21,488)	21	.54	.20
• **Family Variables**								
Family Resources (FRS)[*]	118.4	(22.3)	24	122.4	(15.0)	24	.46	.18
Holmes & Rahe Major Life Events								
Raw Score	151.0	(114.2)	24	163.9	(112.7)	25	.69	-.11
Negative Events Score	32.1	(35.9)	24	29.1	(46.3)	25	.80	.08
• **Teacher Rating of Parent**[$]								
Support	16.6	(3.4)	21	17.8	(3.0)	21	.24	.35
Knowledge	9.2	(2.1)	21	10.0	(1.4)	21	.17	.38
• **Additional Services (% Received)**[*]								
Speech Therapy	4		24	23		22	.10	.48
Physical or Occupational Therapy	29		24	23		22	.66	-.13

(continued)

[$] Data are based on teacher rating of parents' attendance, support, and knowledge range (1-3). Higher scores indicate better ratings.

[*] Analyses for the FRS are based on raw scores indicating number of supports on resources indicated by the family as being available. Higher scores and positive ESs are considered better. Analyses for the FILE are based on raw scores. Lower scores represent less stress and are considered better.

[*] Annually, parents completed an additional services form which described other interventions or additional services the child and family received.

Based on parent rating of the child's health where 1 = worse than peers, 2 = same as peers, 3 = better than peers

NOTE: ESs from percentages were computed from a t statistic after a subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

Table 2.5 (continued)

	Basic Intervention			Expanded Intervention			p	
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	Value	ES^
POSTTEST #6								
• **Child Health**	2.3	(.5)	19	1.9	(.6)	23	.17	-.80
• **Demographics**								
Percent child living with parents	83		18	86		22	.78	.08
Annual Income	$27,082	($24,013)	19	$20,503	($19,437)	20	.35	-.27
• **Family Variables**								
Family Resources (FRS)*	124.4	(16.4)	19	121.2	16.0	23	.53	-.20
Holmes & Rahe								
Raw	141.5	(97.1)	19	115.0	(80.3)	23	.34	.27
Negative Events Scores	47.0	(46.1)	19	21.4	(27.8)	23	.04	.56
• **Teacher Rating of Parent§**								
Support	17.4	(3.4)	13	17.2	(3.3)	19	.85	-.06
Knowledge	10.2	(2.1)	13	9.7	(1.8)	19	.56	-.24
• **Additional Services (hours rerceived)**								
Speech Therapy	3.3	(10.3)	18	7.7	(20.5)	21	.42	.43
Physical/Occupational Therapy	32.8	(76.8)	18	26.8	(73.2)	21	.80	-.08
Services to improve parenting	1.3	(4.8)	18	1.3	(4.3)	21	1.00	.00
Public/private school	1054.3	(96.2)	14	1080.0	(.0)	19	.37	.27
Other Services	23.6	(43.3)	18	29.1	(54.1)	21	.73	.13
POSTTEST #7								
• **Child Health**	2.2	(.6)	11	2.1	(.5)	15	.58	-.17
• **Demographics**								
Percent child living with parents	92		12	100		14	.49	.26
Annual Incomje	$48,333	($8,416)	12	$34,393	($16,324)	14	.01	-1.66
• **Family Variables**								
Family Resources (FRS)	125.0	(14.0)	12	119.5	(22.5)	15	.46	-.39
Holmes and Rahe								
Raw	176.8	(94.9)	12	156.6	(114.0)	15	.63	.21
Negative Events Scores	40.7	(39.3)	12	39.3	(47.7)	15	.94	.04
• **Teacher Rating of Parent**								
Support	14.4	(4.1)	7	17.9	(2.6)	8	.07	.85
Knowledge	8.1	(3.0)	7	10.4	(1.8)	8	.10	.77
• **Additional Services** (hours received)								
Speech Therapy	8.2	(16.9)	11	5.1	(12.5)	13	.61	-.18
Physical/Occupational Therapy	29.8	(38.3)	11	15.4	(34.4)	13	.34	-.38
Services to Improve parenting	60.7	(170.9)	11	.0	(.0)	13	.27	-.36
Public/Private School	301.9	(500.3)	11	263.1	(501.7)	13	.85	-.08
Other Services	114.2	(206.0)	11	41.2	(70.9)	13	.28	-.35

§ Data are based on teacher rating of parents' attendance, support, and knowledge range (1-3). Higher scores indicate better ratings.

* Analyses for the FRS are based on raw scores indicating number of supports on resources indicated by the family as being available. Higher scores and positive ESs are considered better. Analyses for the FILE are based on raw scores. Lower scores represent less stress and are considered better.

* Annually, parents completed an additional services form which described other interventions or additional services the child and family received.

Based on parent rating of the child's health where 1 = worse than peers, 2 = same as peers, 3 = better than peers

NOTE: ESs from percentages were computed from a t statistic after a subject was added to each group in the comparison; those meeting the criteria, and those that did not. This was done to ensure variance in group composition.

contributed (in-kind) and shared resources. In this approach, an exhaustive list of resources used by each alternative is developed, and the ingredients are costed according to observed market values (e.g., salaries) or opportunity cost (e.g., parent time). An opportunity cost is the value of a resource in its next best alternative use. For example, parents participating in intervention activities could have been engaged in other productive activities; these foregone activities represent a cost to parents. Since we have no information about any one individual's opportunity costs, we estimated the value of an individual's time based on national data. The amount of parent or non-parent volunteer time required for the study was assigned the pecuniary value of $9 per hour based on the "median usual weekly earning for full-time work" plus benefits (U.S. Department of Labor, Bureau of Labor Statistics, 1989).

All costs are in 1990 dollars. In cases where program costs were compared over several years, costs were adjusted for inflation using the Fixed Weighted Price Index for state and local government purchases (Bureau of Economic Analysis, 1988). Table 2.6 summarizes average cost per child for 3 days per week versus 1 day per week in the SMA and Lake McHenry locations. These two programs were used as the basis for the calculations since they served the majority of the children included in the project. As can be seen from the table, the cost necessary to expand services from one day per week to three days per week is an additional 6,304 dollars per child.

Table 2.6

Costs per Child for SMA/Lake McHenry (1990 Dollars)

	1 x per week	3 x per week
Direct Services	$2,293	$ 5,561
Administration	979	2,937
Facilities	210	631
Equipment	59	178
Materials/Supplies	83	251
Transportation	83	248
Utilities, Insurance, Miscellaneous	103	308
TOTAL	**$3,810**	**$10,114**

* *Totals may not equal due to rounding errors*

Data Collection

All subjects were tested at program entry and then again each year after enrollment into the program. Table 2.7 presents the schedule of assessment for the pretest and the seven reassessments. Table 2.8 provides a simple description of each of the dependent and contextual measures used for testing. Data collection procedures are described below.

Table 2.7

Schedule of Administration and Test Administration for SMA/Lake McHenry Intensity Study

	Pre.	Reasses. 1	Reasses. 2	Reasses. 3	Reasses. 4	Reasses. 5	Reasses. 6	Reassess. 7
CHILD MEASURES								
Battelle Developmental Inventory	X	X	X	X	X	X	X	
Pictorial Scale of Perceived Competence							X	X
Woodcock-Johnson--Revised							X	X
Bayley Scales		X						
Wisconsin	X	X						
Scales of Independent Behavior			X					X
Child Behavior Checklist				X				
Social Skills Rating Scale						X	X	X
FAMILY MEASURES								
Parent Stress Index	X	X	X	X	X			
Parent Stress Index (Short Form)							X	X
Family Support Scale	X	X	X	X	X	X	X	X
Family Resource Scale	X	X	X	X	X	x	X	X
Family Inventory of Life Events and Changes	X	X	X	X	X			
Family Adaption and Cohesion Evaluation Scales		X	X	X	X	X		
Comprehensive Evaluation of Family Functioning				X	X	X		
Parent Self-Awareness Scale						X	X	X
Holmes & Rahe Major Life Events						X	X	X

Interobserver agreement was calculated for eight BDI administrations and two Bayley administrations. Mean percent agreement was 92.4% for the BDI, 94% for the Bayley Mental Scale, and 100% for the Bayley Motor Scale.

Pretest data collection. Pretesting was accomplished in two phases. The first phase of pretest data collection occurred at the time that parents consented to participate in the study. At that time, parents completed the Parenting Stress

Table 2.8
Description of Tests Administered for SMA/Lake McHenry Intensity Study

MEASURES	DESCRIPTION
CHILD MEASURES	
Battelle Developmental Inventory (BDI) (Newborg et al., 1984)	A norm-referenced test of developmental functioning completed through child administration and parent interview. Assesses personal/social, adaptive, motor, communication, and cognitive skills, and provides a total score.
Woodcock-Johnson Tests of Achievement--Revised (WJ-R) (Woodcock & Johnson, 1989)	A norm-referenced test of achievement. The test consists of six aspects of scholastic achievement: Letter-Word Identification, Applied Problems, Dictation, Science, Social Studies, and Humanities. Child is the respondent.
The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983)	Assesses a child's perceived competence and social acceptance in four specific domains: Cognitive Competence, Physical Competence, Maternal Acceptance, and Peer Acceptance. Child is the respondent.
Scales of Independent Behavior (SIB) (Bruininks et al., 1985)	The SIB is a norm-referenced test which assesses functional independence/adaptive behavior of a child. It is organized into four subdomains: motor skills, and communication skills, personal living skills, and community living skills.
Bayley Scales of Infant Development (Bayley, 1969)	A norm-referenced test which measures infant mental and motor development. It is completed using child administration and parent interview.
Wisconsin Behavior Rating Scale (Song et al., 1984)	A norm-referenced and criterion-referenced test which assesses basic survival skills in 11 areas.
Child Behavior Checklist (Achenbach & Edelbrock, 1986)	A norm-referenced test which assesses problem behaviors and competencies through parent report.
Social Skills Rating Scale (Gresham & Elliott, 1990)	A norm-referenced measure of child social skills and school success. Ratings are obtained from the child's parent and teacher.
FAMILY MEASURES	
Parent Stress Index (PSI) (Abidin, 1986)	Assesses parent perceptions of stress on the parent-child system. The two main domains are child-related factors and parent factors .
Parent Stress Index (Short Form) (Abidin, 1990)	36 item version of the PSI that provides 3 scores: parent distress, parent-child dysfunctional interaction, and difficult child.
Family Support Scale (FSS) (Dunst, Jenkins, & Trivette, 1984)	Assesses the availability of sources of support as well as the degree to which different sources of support provided are perceived as helpful to families rearing young children.
Family Resource Scale (FRS) (Dunst, & Leet, 1985)	Assesses the extent to which different types of resources are perceived as adequate in households with young children. Factors include: general resources, time availability, physical resources, and external support.
Family Inventory of Life Events and Changes (FILE) (McCubbin, Patterson, & Wilson, 1983)	Assesses life events and changes experienced by a family unit during the past 12 months. The specific areas of potential strain covered by the scale include: intra-family, marital, pregnancy and childbearing, finance and business, work-family transitions, illness and family "care," losses, transitions "in and out," and legal.
Family Adaptability and Cohesion Evaluation Scale - III (FACES) (Olson, Portner, & Lavee, 1985)	Provides a general picture of family functioning by assessing family level of adaptability/cohesion. Family cohesion assesses degree of separation or of family members to family. Adaptability assesses the extent to which family is flexible and able to change in various situations. The scale also has a perceived and ideal form that provides an indication of extent to which current family functioning is consistent with family expectation for ideal family functioning.
Comprehensive Evaluation of Family Functioning (CEFF) (McLinden, 1989)	Assesses areas in which a family having a child with special needs may be affected. Areas assessed are: time demands, acceptance, coping, social relationships, financial demands, well-being, and sibling relationships.
Parent Self-Awareness Scale (PSAS) (Snyder et al., 1985)	Assesses parent perceptions of empowerment in the areas of decision making, obtaining information, and in interactions with self and others.
Holmes & Rahe Major Life Events (Holmes & Rahe, 1967)	Assesses parent stress resulting from major life events that occurred within the past year.

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Index, and the educator or specialist assigned to the family's case completed the Wisconsin Behavior Rating Scale. These data were then used for stratification purposes during random assignment.

After the subjects had been assigned to a group, the diagnostician contacted the parent and scheduled a testing session to complete the remainder of the pretest battery, consisting of the Battelle Developmental Inventory (BDI), the Family Support Scale (FSS), Family Resource Scale (FRS), the Family Inventory of Life Events and Changes (FILE), and Family Adaptability and Cohesion Evaluation Scales (FACES III). Testing occurred at one of the program sites closest to the parent's home, although in some instances it was necessary to schedule testing at the home. Parents were paid $20 to participate in the approximately 1½ hour testing session. Most subjects were tested within two weeks of their assignment to groups.

Year 1 reassessment. The first reassessment was scheduled 12 months after the date upon which the subject first entered services. However, the average amount of time between pretest and the first reassessment was less than 12 months, due primarily to delays in pretesting some of the children. The time between pretest and the first reassessment did not, however, differ significantly across groups.

The reassessment battery consisted of a large number of child and family measures, which necessitated the scheduling of two separate testing sessions. The first session, which lasted approximately 1¾ to 2¼ hours and for which parents were paid $20, included the administration of the BDI, PSI, FILE, FRS, FSS, and FACES III. The second session, which lasted approximately 1½ hours and for which parents were paid $15, included administration of Bayley Scales of Infant Development, Parent Survey Form, Parent Report of Child's Health, and Parent Satisfaction with Services. A videotape of an interaction session between the child and his/her primary caregiver was also made at this time. Each child's specialist or educator also completed the Wisconsin Behavior Rating Scale at the time of the first reassessment.

Year 2 reassessment. Subjects were tested again two years after their initial program entry date. The reassessment battery was administered in two sessions in a manner similar to the first reassessment. The second reassessment differed from the first reassessment as follows: (1) The Scales of Independent Behavior replaced the Bayley Scales and the Wisconsin Behavior Rating Scale as a child outcome measure, (2) Fathers and mothers completed the Comprehensive Evaluation of Family Functioning Scale, and (3) Fathers completed the FSS and FACES III.

Year 3 reassessment. The reassessment battery was administered in only one session. Some of the parent forms (parent survey, satisfaction questionnaire, and health form) were sent to the parents to be completed before the testing session, and data on additional services were collected by the assessment coordinator in a phone call with the parent after testing had been completed. One other measure (teacher rating form) was completed by the child's current teacher. Other measures for the third reassessment included the Child Behavior Checklist (CBC) to assess possible problem behaviors and the Comprehensive Evaluation of Family Functioning (completed by both mothers and fathers) to obtain a more global assessment of the subject families. Fathers also completed the FSS and FACES III.

Year 4 reassessment. The reassessment battery for child measures was again done in one session. And as in previous years, some of the parent forms were sent to parents to be completed before the testing session. All measures used in third reassessment were again used in the fourth reassessment with one exception; the CEFF was only completed by the mothers.

Year 5 reassessment. The reassessment battery for child measures was done in one session. One additional child measure was given for Year 5, that was the Social Skills Rating Scale; this scale was completed by the subject's teacher. Parent forms were sent to the parents so that the forms could be complete when the child's session was scheduled. The Parenting Stress Index and the Family Inventory of Life Events and Changes were replaced by the Holmes and Rahe Major Life Events Scale. In addition, the use of the FACES were also discontinued. All other family measures were given as usual, with the CEFF being filled out by the mothers. An additional measure of family functioning was given to parents (Parent Self-Awareness Scale) to assess perceived empowerment of family decision makers.

Year 6 reassessment. The child reassessment battery was done in one session. The child measures included the BDI, the SSRS (completed by both the teacher and parent), the achievement section of the Woodcock-Johnson Tests of Achievement (Woodcock & Johnson, 1989), and the Pictorial Scale of Perceived Competence and Social Acceptance (Harter & Pike, 1984). The Woodcock-Johnson will replace the BDI in the seventh reassessment, but because so many of the subjects in this study may not function at a high enough level for the Woodcock-Johnson to measure their development, the achievement portion was given as means of connecting previous years scores, and to assess the usability of the Woodcock-Johnson for further use. Parent forms were sent to the parents so that the forms could be complete when the child's session was scheduled. The family measures included: the FRS, the FSS, the PSAS, the PSI short form, and the Holmes and Rahe Major Life Events Scale. All of these measures were filled out by the mothers.

Year 7 Reassessment. The Battelle Developmental Inventory was not used in this reassessment. Instead, the achievement portion of the Wookcock-Johnson Tests of Achievement and the Scales of Independent Behavior were given to assess child development. The remaining assessment was identical to Year [illegible].

Results and Discussion

Pretest Comparisons

Results of comparisons of the Expanded and Basic Services groups on the measures collected at pretest for all subjects as well as those subjects included in all reassessments are presented in Table 2.9. Probability values presented in the table are based on one-way analysis of variance. For the completc reassessments, group differences appeared for the FACES adaptability score with all pretested subjects, the FILE for subjects used in Reassessments #3, #4, and #6 the FRS for subjects used in Reassessments #5 and #6; and the FSS for subjects used in Reassessment #6. An examination of all other values indicated that, at pretest, experimental and control groups were not statistically significantly ($p < .10$) different on any of the measures of child or family functioning and that attrition did not significantly affect the comparability of groups at any complete reassessment. The few differences observed are accounted for in the analysis using them as covariates when appropriate. Analysis of comparability between groups at pretest for those subjects used in the seventh reassessment showed differences on several family measures. These differences may well disappear when the testing is complete.

Selection of Covariates

The choice of covariates for the analysis procedures was conducted using three methods. First, demographic, contextual, and outcome variables in which groups differed at pretest were considered as possible covariates. They were used if their correlation with the outcome measure indicated that there was a sufficient relationship to adjust means to account for the pretreatment differences. If the correlation was insignificant, then the variable was not used as a covariate.

Second, in the case of child measures, raw scores were analyzed; thus, age was used as a covariate. This eliminated the need for age adjusted scores and developmental quotients which were not appropriately normed for samples with severe disabilities.

Table 2.9

Comparability of Groups on Pretest Measures for SMA/Lake-McHenry Project

	All Pretested Subjects								Subjects Included in Year #1 Reassessment										
	Basic Intervention			Expanded Intervention					Basic Intervention				Expanded Intervention						
Variable	$\bar{X}$	(SD)	n	$\bar{X}$	(SD)	n	ES	P Value	$\bar{X}$	(SD)	%ile	n	$\bar{X}$	(SD)	%ile	n	ANOVA F	ES	P Value
• Age in months at pretest	15.1	(6.4)	39	13.3	(6.4)	33	-.28	.24	15.2	(6.1)		18	12.5	(5.8)		17	1.78	-.44	.19
• **Battelle Developmental Inventory (BDI)**																			
Raw Scores for:																			
Personal Social	30.9	(16.5)	39	31.0	(16.4)	33	.01	.98	30.4	(16.1)		31	31.6	(16.8)		29	0.08	.07	.78
Adaptive Behavior	25.2	(13.6)	39	24.8	(13.1)	33	-.03	.92	24.0	(13.3)		31	25.2	(13.0)		29	0.13	.09	.72
Motor	34.7	(26.3)	39	32.5	(23.1)	33	-.08	.72	32.9	(25.0)		31	32.0	(23.1)		29	0.00	-.04	.99
Communication	16.6	(8.0)	39	16.9	(9.0)	33	.04	.86	16.2	(7.9)		31	17.3	(9.3)		29	0.25	.14	.62
Cognitive	14.8	(9.1)	39	15.2	(8.4)	33	.04	.86	14.5	(9.0)		31	15.6	(8.3)		29	0.23	.12	.64
TOTAL	122.2	(71.6)	39	120.5	(67.5)	33	-.02	.92	117.9	(69.2)		31	122.5	(67.7)		29	0.07	.07	.80
• **Parenting Stress Index**[§◆] **(PSI)** Percentile Rank																			
Child Related (range 47 to 235)	117.3	(27.1)	39	110.3	(19.8)	33	.26	.22	119.9	(28.0)	88	31	111.1	(19.9)	76	29	)4	.31	.17
Other Related (range 54 to 270)	127.1	(23.1)	39	124.7	(28.7)	33	.10	.70	128.4	(24.8)	63	31	124.8	(30.5)	58	29	0.25	.15	.62
TOTAL (range 101 to 505)	244.4	(42.4)	39	235.0	(41.9)	33	.22	.35	248.3	(44.0)	78	31	235.9	(43.9)	67	29	1.18	.28	.28
• **Family Adaptability and Cohesion Evaluation Scales (FACES)**																			
Adaptability	21.1	(5.2)	38	24.7	(6.3)	33	.69	.07	22.1	(5.4)		30	24.6	(6.3)		29	1.10	.46	.11
Cohesion	38.1	(7.9)	38	37.6	(7.0)	33	-.06	.79	37.4	(7.7)		30	38.1	(6.8)		29	0.01	.09	.69
• **Family Resource Scale**[**] **(FRS)**	118.5	(24.3)	37	119.0	(15.2)	30	.02	.92	120.1	(25.7)	54	29	118.0	(15.7)	50	27	0.13	-.08	.71
• **Family Index of Life**[◆§] **Events (FILE)**	11.3	(7.9)	38	12.6	(7.2)	33	-.16	.47	10.9	(8.1)	34	30	12.6	(6.0)	24	29	0.75	-.21	.39
• **Family Support Scale**[**] **(FSS)**	29.5	(12.3)	37	28.5	(10.2)	33	-.08	.71	30.5	(12.9)	63	30	27.7	(9.4)	50	29	0.91	-.22	.34

(continued)

◆ Statistical analysis and Effect Size (ES) for PSI and FILE were based on raw scores where low raw scores and positive ES are most desirable.

[**] Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

[§] No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on all pretests collected as part of the Longitudinal studies.

Statistical analysis for BDI scores was conducted using raw scores for each of the scales.

Scores for each subscale of the FACES are based on linear scoring where high scores are preferred.

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Table 2.9 (continued)

Comparability of Groups on Pretest Measures for SMA/Lake-McHenry Project

	Subjects Included in Year #2 Reassessment									Subjects Included in Year #3 Reassessment								
	Basic Intervention			Expanded Intervention						Basic Intervention			Expanded Intervention					
Variable	X̄	(SD)	n	X̄	(SD)	n	ANOVA F	ES	P Value	X̄	(SD)	n	X̄	(SD)	n	ANOVA F	ES	P Value
• Age in months at pretest	15.0	(6.4)	28	12.5	(5.6)	21	2.02	-.39	.16	15.8	(6.3)	22	12.4	(5.6)	16	2.88	-.54	.10
• **Battelle Developmental' Inventory (BDI)**																		
Raw Scores for:																		
Personal Social	30.4	(16.9)	28	28.1	(12.4)	21	0.26	-.14	.62	33.9	(16.8)	22	28.2	(14.1)	16	1.23	-.34	.27
Adaptive Behavior	23.5	(13.6)	28	23.4	(9.3)	21	0.00	-.01	.98	26.1	(13.8)	22	23.4	(10.0)	16	0.42	-.20	.52
Motor	31.7	(25.9)	28	29.0	(17.0)	21	0.17	-.10	.68	36.2	(27.3)	22	29.8	(19.2)	16	0.66	-.23	.42
Communication	15.9	(8.3)	28	14.8	(6.9)	21	0.25	-.13	.62	17.5	(8.3)	22	14.3	(7.0)	16	1.56	-.39	.22
Cognitive	14.2	(9.3)	28	14.5	(6.4)	21	0.02	.03	.89	16.0	(9.0)	22	14.3	(6.9)	16	0.37	-.19	.55
TOTAL	115.6	(72.1)	28	109.9	(48.1)	21	0.10	-.08	.75	129.7	(73.5)	22	110.0	(53.4)	16	0.83	-.27	.37
• **Parenting Stress Index♦ (PSI) Percentile Rank**																		
Child Related (range 47 to 235)	120.9	(29.3)	28	115.0	(16.5)	21	0.70	.20	.37	118.6	(30.1)	22	115.1	(17.6)	16	0.17	.12	.66
Other Related (range 54 to 270)	125.9	(24.0)	28	128.0	(32.0)	21	0.07	-.09	.79	123.4	(26.2)	22	128.2	(36.7)	16	0.22	-.18	.64
TOTAL (range 101 to 505)	246.8	(45.5)	28	243.0	(41.2)	21	0.09	.08	.76	242.0	(48.3)	22	243.3	(46.8)	16	0.06	-.03	.93
• **Family Adaptability and Cohesion Evaluation Scales (FACES)**																		
Adaptability	22.6	(5.3)	27	23.6	(6.7)	21	1.73	.19	.59	24.0	(4.8)	21	23.7	(7.0)	16	0.03	-.06	.85
Cohesion	38.3	(7.2)	27	37.6	(5.4)	21	0.04	-.10	.72	39.0	(7.7)	21	38.0	(6.8)	16	0.15	-.13	.70
• Family Resource Scale' **(FRS)**	120.5	(26.7)	26	116.9	(16.9)	21	0.29	-.13	.59	123.8	(27.3)	20	115.7	(17.0)	16	1.08	-.30	.31
• **Family Index of Life♦ Events (FILE)**	10.7	(8.6)	27	13.2	(6.2)	21	1.27	.29	.27	9.9	(6.6)	21	13.6	(6.5)	16	2.99	-.56	.09
• **Family Support Scale' (FSS)**	29.3	(12.5)	27	26.9	(9.1)	21	0.54	-.19	.46	29.6	(10.7)	21	27.6	(9.2)	16	0.36	-.19	.55

(continued)

♦ Statistical analysis and Effect Size (ES) for PSI and FILE were based on raw scores where low raw scores and positive ES are most desirable.

' Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

' Statistical analysis for BDI scores was conducted using raw scores for each of the scales.

Scores for each subscale of the FACES are based on linear scoring where high scores are preferred.

Table 2.9 (continued)

Comparability of Groups on Pretest Measures for SMA/Lake-McHenry Project

	Subjects Included in Year #4 Reassessment									Subjects Included in Year #5 Reassessment								
	Basic Intervention			Expanded Intervention						Basic Intervention			Expanded Intervention					
Variable	X̄	(SD)	n	X̄	(SD)	n	ANOVA F	ES	P Value	X̄	(SD)	n	X̄	(SD)	n	ANOVA F	P Value	ES^
• **Age in months at pretest**	15.0	(6.1)	20	12.9	(5.9)	18	1.12											
• **Battelle Developmental' Inventory (BDI)**																		
Raw Scores for:																		
Personal Social	33.2	(15.4)	20	29.3	(13.0)	18	0.69			32.6	(14.3)	24	31.2	(16.7)	25	0.10	.76	-.10
Adaptive Behavior	25.6	(12.2)	20	24.2	(9.7)	18	0.15			25.8	(12.3)	24	24.9	(13.0)	25	0.07	.79	-.07
Motor	35.0	(26.0)	20	30.1	(18.0)	18	0.45			35.5	(26.7)	24	32.0	(22.8)	25	0.28	.60	-.13
Communication	17.6	(7.5)	20	15.6	(7.1)	18	0.70			17.3	(7.1)	24	16.9	(9.3)	25	0.02	.88	-.06
Cognitive	16.2	(8.0)	20	15.1	(6.8)	18	0.20			16.3	(7.7)	24	15.7	(8.4)	25	0.07	.79	-.08
TOTAL	127.5	(67.1)	20	114.3	(50.7)	18	0.46			127.5	(63.8)	24	120.6	(67.5)	25	0.14	.72	-.11
• **Parenting Stress Index◆ (PSI) Percentile Rank**																		
Child Related (range 47 to 235)	109.5	(18.7)	20	113.2	(16.8)	18	0.43			113.5	(24.5)	24	110.4	(20.8)	25	0.23	.64	.13
Other Related (range 54 to 270)	118.5	(21.9)	20	131.1	(32.8)	18	1.98			122.0	(22.6)	24	124.0	(31.8)	25	0.06	.81	-.09
TOTAL (range 101 to 505)	228.0	(33.7)	20	244.3	(44.3)	18	1.66			235.5	(37.9)	24	234.4	(45.7)	25	-.01	.93	.03
• **Family Adaptability and Cohesion Evaluation Scales (FACES)**																		
Adaptability	24.1	(5.0)	19	23.6	(6.8)	18	0.11			23.3	(5.1)	23	24.7	(6.2)	25	-.61	.44	.27
Cohesion	40.1	(5.0)	19	37.8	(6.7)	18	1.68			38.9	(6.9)	23	37.5	(6.8)	25	0.15	.70	-.20
• **Family Resource Scale** (FRS)**	126.4	(22.6)	18	115.5	(16.1)	18	2.80			126.4	(20.9)	22	117.5	(16.8)	23	2.50	.12	-.43
• **Family Index of Life◆* Events (FILE)**	9.6	(5.8)	19	13.6	(6.0)	18	3.33			9.7	(5.7)	23	12.8	(6.1)	25	2.33	.13	-.54
• **Family Support Scale** (FSS)**	33.1	(11.5)	19	27.8	(9.0)	17	2.26			34.0	(11.7)	23	28.9	(8.6)	25	4.03	.05	-.44

◆ Statistical analysis and Effect Size (ES) for PSI and FILE were based on raw scores where low raw scores and positive ES are most desirable.

* Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

Statistical analysis for BDI scores was conducted using raw scores for each of the scales.

Scores for each subscale of the FACES are based on linear scoring where high scores are preferred.

Table 2.9 (continued)

Comparability of Groups on Pretest Measures for SMA/Lake-McHenry Project

	Delayed Intervention			Early Intervention				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
REASSESSMENT #6								
• Age in months at pretest	15.1	(6.4)	19	12.6	(5.6)	23	-.39	.18
• **Battelle Developmental* Inventory (BDI)**								
Raw Scores for:								
Personal Social	31.6	(15.5)	19	29.1	(14.9)	23	-.16	.60
Adaptive Behavior	24.1	(12.2)	19	22.9	(10.9)	23	-.10	.75
Motor	32.6	(25.1)	19	28.2	(19.4)	23	-.18	.52
Communication	16.4	(7.5)	19	16.1	(7.7)	23	-.04	.92
Cognitive	14.8	(7.9)	19	14.4	(7.4)	23	-.05	.85
TOTAL	119.5	(66.3)	19	110.7	(57.5)	23	-.13	.65
• **Parenting Stress Index'** **(PSI)** Percentile Rank								
Child Related (range 47 to 235)	117.8	(21.5)	19	111.8	(18.6)	23	.28	.37
Other Related (range 54 to 270)	125.2	(20.3)	19	127.9	(33.0)	23	-.13	.75
TOTAL (range 101 to 505)	242.9	(32.9)	19	239.7	(44.9)	23	.10	.79
• **Family Adaptation and' Cohesion Evaluation Scales (FACES)**								
Adaptation	24.0	(5.2)	19	24.6	(6.4)	23	.12	.71
Cohesion	40.4	(6.4)	19	38.0	(6.9)	23	-.38	.47
• **Family Resource Scale‘ (FRS)**	132.4	(12.6)	19	115.3	(15.8)	21	-1.36	.00
• **Family Index of Life' Events (FILE)**	10.1	(4.8)	19	13.8	(5.5)	23	-.77	.03
• **Family Support Scale‘ (FSS)**	35.9	(11.4)	19	28.6	(8.9)	23	-.64	.01

(continued)

♦ Statistical analysis and Effect Size (ES) for PSI and FILE were based on raw scores where low raw scores and positive ES are most desirable.

‘ Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

· Statistical analysis for BDI scores was conducted using raw scores for each of the scales.

' Scores for each subscale of the FACES are based on linear scoring where high scores are preferred.

Table 2.9 (continued)

Comparability of Groups on Pretest Measures for SMA/Lake-McHenry Project

	Delayed Intervention			Early Intervention				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
REASSESSMENT #7								
• Age in months at pretest	15.9	(6.7)	12	12.0	(5.7)	15	-.58	.11
• **Battelle Developmental Inventoroy (BDI)**								
Raw Scores for:								
Personal/Social	31.8	(17.2)	12	25.8	(13.7)	15	-.35	.32
Adaptive Behavior	22.3	(13.4)	12	19.7	(9.8)	15	-.19	.57
Motor	30.4	(27.9)	12	22.9	(16.3)	15	-.27	.39
Communication	15.8	(7.5)	12	15.0	(7.7)	15	-.11	.78
Cognitive	13.4	(8.6)	12	12.3	(6.9)	15	-.13	.70
TOTAL	113.8	(72.8)	12	95.7	(52.3)	15	-.25	.46
• **Parenting Stress Index (PSI) Percentile Rank**								
Child Related (range 47 to 235)	121.3	(27.1)	12	113.2	(19.6)	15	.30	.38
Other Related (range 54 to 270)	127.3	(17.0)	12	124.1	(33.6)	15	.19	.76
TOTAL	248.6	(32.0)	12	237.3	(45.0)	15	.35	.47
• **Family Adaptability and Cohesion Evaljation Scales (FACES)**								
Adaptability	24.3	(4.5)	12	23.0	(7.1)	15	-.29	.60
Cohesion	40.3	(7.6)	12	37.7	(7.8)	15	-.34	.68
• **Family Resource Scale (FRS)**	133.6	(10.9)	12	118.9	(17.6)	13	-1.35	.02
• **Family Index of Life Events (FILE)**	10.1	(4.9)	12	12.9	(5.4)	15	-.57	.09
• **Family Support Scale (FSS)**	34.0	(8.1)	12	28.4	(9.8)	15	-.69	.03

Finally, variables which correlated with the outcome variable to make at least a marginal increase in power were included as covariates. If two related variables made this list, then the most appropriate was chosen as the statistical overlap would serve to negate the attempted increase in power. In as many cases as possible, at least one demographic, one child functioning, and one family variable were used as covariates. This increase in power was included to demonstrate that even under the most liberal statistical conditions, differences were very hard to detect. In addition, this increase in power helped offset the loss of power due to attrition. For example, sample sizes obtained at the fourth reassessment, the power (i.e., the ability to detect differences) obtained to detect moderate effects (in this case, effect sizes of .50 or better) were approximately 45%. With covariates producing a multiple of R .70, as was the case for most of the child measures analyses, power increased to over 90%. Thus, despite the attrition, the ability to detect even moderate differences was substantial.

Reassessment Analyses for Year 1

Results of group comparisons on child outcome measures for Year 1 are presented in Table 2.10. Analysis of the data for the three measures of child functioning--BDI, Wisconsin, and Bayley Scales--indicated that there were no statistically significant differences between the groups in favor of the more intensive group after one year of intervention.

All of the effect sizes for child functioning as measured by the Battelle and the Bayley were negative. This indicated that across all domains, the less intensive group scored higher after adjusting for pretreatment differences and the age of each child. Additionally, three of these variables, including the total score on the Battelle, showed a statistically significant difference in favor of the basic group.

Results of the group comparisons for the family outcome measures for Year One are presented in Table 2.11. Statistically significant group differences were found on the Family Support Scale. Mother's FSS total score for adequacy of support was higher (p = .04) for the mothers in the expanded intervention than for those in the control group. This indicates that mothers who participated in services three times per week reported higher levels of helpfulness for available sources of support than did mothers who participated in services once per week. There were no statistically significant differences on any of the other family measures.

Table 2.10

Year 1 Reassessment Measures of Child Functioning for Alternative Intervention Groups for SMA/Lake-McHenry

Variable Value	Covariates◆	Basic Intervention $\bar{x}$	(SD)	Adj $\bar{x}$	n	Expanded Intervention $\bar{x}$	(SD)	Adj $\bar{x}$	n	ANCOVA F	ES	p
Average Length of Time between Pretest & Reassessment		10.7	(1.8)		31	10.4	(2.6)		29	0.21	.17	.65
Age in months at Reassessment		25.1	(6.3)		31	24.2	(7.3)		29	1.42	.14	.24
Battelle Developmental' Inventory Raw Scores for:												
Personal/Social	1,2,3	50.5	(26.1)	52.7	31	49.0	(23.0)	46.9	29	6.24	-.22	.02
Adaptive Behavior	1,2,3	36.4	(17.3)	38.0	31	37.4	(14.5)	35.9	29	2.13	-.12	.15
Motor	1,2,3	54.7	(31.2)	57.4	31	52.1	(26.6)	49.4	29	5.23	-.26	.03
Communication	1,2,3	26.6	(13.3)	27.8	31	27.4	(11.8)	26.2	29	1.33	-.12	.25
Cognitive	1,2,3	22.6	(12.4)	23.7	31	23.7	(9.6)	22.6	29	1.10	-.09	.30
Total	1,2,3	190.9	(97.9)	199.6	31	189.7	(81.6)	181.0	29	6.41	-.19	.01
Bayley Scales'												
Mental	2,3,4	104.3	(51.9)	109.7	31	112.5	(38.3)	107.0	29	0.22	-.05	.64
Motor	2,3,5	46.2	(23.0)	47.6	31	47.2	(18.0)	45.8	29	0.82	-.08	.37
Wisconsin												
Deviation Score	3,6	.6	(.4)	.6	31	.7	(.3)	.7	29	0.30	.11	.59
Behavior Age	2,3,7	16.2	(10.6)	16.1	31	16.2	(9.5)	16.3	29	0.02	.02	.89

◆ 1 = Battelle Total Raw Score (pretest), 2 = Age of child at pretest, 3 = PSI child related (pretest), 4 = Battelle cognitive raw score (pretest), 5 = Battelle total motor raw score (pretest), 6 = Wisconsin deviation score (pretest), 7 = Wisconsin behavior age score (pretest)

Statistical analysis for assessment instruments was conducted using raw scores for each of the scales.

Table 2.11

Year 1 Reassessment Measures of Family Functioning for Alternative Intervention Groups for SMA/Lake-McHenry

Variable	Covariates◆	Basic Intervention $\bar{x}$	(SD)	Adj $\bar{x}$	n	Expanded Intervention $\bar{x}$	(SD)	Adj $\bar{x}$	n	ANCOVA F	ES	p Value
• **Parenting Stress Index'**												
Child	1,2,3	119.2	(20.6)	118.8	31	110.9	(22.8)	111.8	29	2.84	.34	.10
Parent	1,2,3	128.0	(26.5)	127.2	31	130.9	(35.5)	132.5	29	0.75	-.20	.39
Total	1,2,3	247.2	(40.5)	245.9	31	241.9	(52.6)	244.4	29	0.04	.04	.85
• **Family Adaptability and'' Cohesion Evaluation Scales III (FACES III) - Mother**												
Adaptability	4,6,7	22.9	(5.7)	23.2	31	23.2	(6.5)	22.3	29	0.50	.16	.48
Cohesion	5,6	38.7	(6.8)	38.9	31	39.3	(4.8)	38.8	29	0.01	.01	.92
• **Family Support Scale (FSS) - Mother**	6,8	26.9	(10.2)	26.3	31	29.8	(10.4)	30.6	29	4.40	.42	.04

◆ 1 = PSI Total (pretest), 2 = FILE (pretest), 3 = Ethnicity of child (Caucasian/non-Caucasian), 4 = FACES adaptability (pretest), 5 = FACES cohesion (pretest), 6 = Maternal age, 7 = Battelle total raw score (pretest), 8 = Family support scale (pretest)

' Lower scores on the Parent Stress Index are considered better.

'' Raw scores for the FACES were used and higher scores are considered better.

Videotapes of parent/child interactions were obtained for 62 subjects at the first reassessment. EIRI contracted with several researchers who had developed scoring systems for such videotapes to have them independently analyzed (Kofi Marfo, Gerald Mahoney, and Dale Farran). This arrangement ensured that the tapes would be analyzed by people who were thoroughly familiar with the scoring system being used and were uninformed about the group membership of participating subjects.

The results of the Marfo analysis of the parent-child interaction are included in Table 2.12. Out of 35 variables tested, a statistically significant difference was found for only one--Child Complies with Mother's Verbal Instruction. This is no more than would be expected to be found by chance when so many variables are being tested. The results of the Farran and Mahoney analyses of the parent/child interaction tapes are included in Table 2.13 and 2.14, respectively. There were no statistically significant differences between the groups on any of the variables coded in these analyses. Thus, it does not appear that there are meaningful differences at the first reassessment between the two groups in terms of parent/child interaction as rated by Marfo, Mahoney, and Farran.

Subgroup Analyses for Reassessment 1

To examine the relative effectiveness of once-per-week versus three-times-per-week services, two subgroup analyses were conducted. The first of these excluded subjects with mild disabilities. The remaining subjects functioned at overall developmental levels more than two standard deviations below average. In the second subgroup analysis, only those children attending their respective programs more than two-thirds of the time were included. Although a variety of attendance rates would be expected in programs of this type, this subgrouping was done to examine a more direct comparison of one versus three times-per-week services. In both cases, the results were not very dissimilar from those using the full groups. All child measures were found to favor the basic group with some subdomains and, in the case

Table 2.12

Year 1 Reassessment Analyses for Videotapes of Parent/Child Interaction Analysis for SMA/Lake-McHenry

Variables	Low Intensity			High Intensity			ANCOVA F	p Value
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n		
• Parent verbal mand	4.1	(4.6)	26	3.9	(1.2)	25	.03	.87
• Parent nonverbal mand	.2	(.3)	26	.2	(.2)	25	.31	.58
• Parent verbal response	1.0	(.6)	26	1.1	(.4)	25	.49	.49
• Parent nonverbal response	.2	(.3)	26	.2	(.2)	25	.21	.64
• Parent verbal response mand	.2	(.3)	26	.2	(.1)	25	.16	.69
• Parent nonverbal response mand	.0	(.0)	26	.0	(.0)	25	2.19	.14
• Parent verbal unlinked	1.9	(1.1)	26	1.7	(.6)	25	.21	.65
• Parent nonverbal unlinked	1.3	(.7)	26	1.3	(.4)	25	.34	.56
• Child verbal mand	.1	(.3)	26	.1	(.2)	25	.12	.73
• Child nonverbal mand	.1	(.2)	26	.2	(.2)	25	1.09	.30
• Child verbal response	1.3	(3.9)	26	.5	(.8)	25	1.03	.31
• Child nonverbal response	1.8	(.9)	26	1.9	(.6)	25	.16	.69
• Child verbal response mand	.0	(.0)	26	.0	(.0)	25	.96	.33
• Child nonverbal response mand	.0	(.0)	26	.0	(.0)	25	--	--
• Child verbal unlinked	.0	(.1)	26	.0	(.0)	25	.01	.90
• Child nonverbal unlinked	1.4	(.7)	26	1.5	(.5)	25	.21	.65
• Parent initiates topic	.9	(.5)	26	.9	(.2)	25	.01	.91
• Parent follows topic	.3	(.4)	26	.4	(.2)	25	.18	.67
• Child follows topic	.7	(.5)	26	.7	(.2)	25	.00	.94
• Child initiates topic	.4	(.4)	26	.5	(.2)	25	1.27	.26
• Parent verbal inhibition	.1	(.1)	26	.1	(.1)	25	1.69	.20
• Parent nonverbal inhibition	.1	(.1)	26	.1	(.1)	25	.89	.35
• Parent intrusion (inadvertent)	.1	(.1)	26	.1	(.1)	25	1.41	.24
• Child complies with verbal inhibition	.0	(.1)	26	.1	(.1)	25	4.51	.04
• Child complies with nonverbal inhibition	.1	(.1)	26	.1	(.1)	25	3.04	.09
• Parent standard imperative	1.8	(.8)	26	2.2	(.7)	25	3.56	.06
• Parent embedded/implied directive	.6	(.7)	26	.7	(.4)	25	.11	.74
• Child complies with standard imperative	.9	(.4)	26	1.0	(.4)	25	1.25	.27
• Child complies with embedded/implied directive	.4	(.7)	26	.2	(.2)	25	.85	.36
• Parent labels	.4	(.2)	26	.4	(.2)	25	.06	.80
• Parent expands	.1	(.1)	26	.0	(.1)	25	.66	.42
• Parent gives information	.6	(.5)	26	.6	(.3)	25	.00	.97
• Parent requests information	1.5	(2.4)	26	1.2	(.7)	25	.29	.59
• Parent models	.7	(.3)	26	.8	(.5)	25	1.23	.27
• Parent reinforces	.4	(.3)	26	.3	(.3)	25	.07	.79

Table 2.13

Year 1 Reassessment Parent/Child Interaction Ratings by Farran for Alternative Intervention Groups for SMA/Lake McHenry

Variable	Basic Intervention			Expanded Intervention			ANOVA F	P Value
	$\bar{X}$	(SD)	n	$\bar{X}$	(SD)	n		
AMOUNT								
1. Principal Involvement	2.9	(1.30)	21	3.2	(1.20)	18		
2. Verbal Involvement	3.5	(.68)	21	3.4	(.70)	18		
3. Responsiveness of Caregiver	3.2	(.81)	21	3.7	(.59)	18		
4. Play Interaction	3.6	(.92)	21	3.6	(.78)	18		
5. Teaching Behavior	1.2	(.44)	21	1.2	(.38)	18		
6. Control Activities	3.6	(.92)	21	3.7	(.90)	18		
7. Directiveness, Demands	2.8	(.89)	21	3.2	(1.00)	18		
8. Relationship Among Activities	3.9	(.77)	21	3.9	(.83)	18		
9. Positive Statements, Regard	2.2	(.99)	21	2.4	(.85)	18		
10. Negative Statements, Regard	1.9	(.89)	21	1.8	(.71)	18		
11. Goal Setting	1.6	(.92)	21	1.8	(1.00)	18		
12. Total for Amount	30.5	(3.78)	21	31.7	(4.80)	18	0.76	.39
QUALITY								
1. Physical Involvement	3.7	(.77)	17	3.9	(.75)	17		
2. Verbal Involvement	3.8	(.51)	21	3.9	(.73)	18		
3. Responsiveness of Caregiver	3.8	(.75)	21	3.9	(.68)	18		
4. Play Interaction	3.8	(.70)	21	3.8	(.73)	18		
5. Teaching Behavior	3.8	(1.30)	5	3.8	(.50)	4		
6. Control Activities	3.8	(.77)	21	3.8	(.88)	17		
7. Directiveness, Demands	3.9	(.64)	20	3.6	(.79)	17		
8. Relationship Among Activities	3.3	(.85)	21	3.5	(.79)	18		
9. Positive Statements, Regard	3.7	(.46)	15	4.0	(.63)	16		
10. Negative Statements, Regard	3.8	(.83)	18	3.4	(.79)	12		
11. Goal Setting	3.9	(.60)	9	3.6	(.70)	10		
12. Total for Quality	32.7	(5.50)	21	32.4	(8.90)	18	0.02	.89
APPROPRIATENESS								
1. Physical Involvement	4.1	(.43)	17	4.1	(1.20)	17		
2. Verbal Involvement	3.5	(.81)	21	3.7	(.58)	18		
3. Responsiveness of Caregiver	3.8	(.77)	21	3.6	(.62)	18		
4. Play Interaction	3.9	(.57)	21	3.9	(.83)	18		
5. Teaching Behavior	3.8	(.45)	5	4.0	(.82)	4		
6. Control Activities	3.6	(.75)	21	3.6	(.79)	17		
7. Directiveness, Demands	4.0	(.65)	20	3.9	(.56)	17		
8. Relationship Among Activities	3.3	(.72)	21	3.7	(.69)	18		
9. Positive Statements, Regard	4.3	(.59)	15	3.8	(.75)	16		
10. Negative Statements, Regard	3.8	(.73)	13	3.8	(.58)	12		
11. Goal Setting	4.0	(.71)	9	3.9	(.74)	10		
12. Total for Appropriateness	33.0	(5.40)	21	32.7	(8.80)	18	0.03	.87
GENERAL IMPRESSION								
1. Availability	4.2	(.83)	21	4.4	(.71)	18	1.16	.29
2. Acceptance	4.1	(.70)	21	3.9	(.90)	18	0.03	.86
3. Atmosphere	3.8	(.98)	21	3.6	(.70)	18	0.04	.83
4. Enjoyment	3.5	(.68)	21	3.8	(.88)	18	1.70	.20
5. Learning Environment	3.4	(.93)	21	3.5	(.86)	18	0.07	.79
AVERAGE RATINGS								
1. Amounts	2.8	(.34)	21	4.5	(6.9)	18	1.37	.25
2. Quality	3.7	(.52)	21	6.6	(11.9)	18	1.19	.28
3. Appropriateness	3.8	(.48)	20	4.9	(4.6)	18	1.16	.29
4. General Impression	3.8	(.67)	21	8.8	(21.3)	18	1.15	.29

Table 2.14

Year 1 Reassessment Parent/Child Interaction Ratings by Mahoney for Alternative Intervention Groups for SMA/Lake McHenry

	Basic Intervention			Expanded Intervention				
Variable	x̄	(SD)	n	x̄	(SD)	n	p Value	ES
Affect	3.31	(.69)	31	3.24	(.56)	31	.71	-.09
Child Orientation	3.17	(.91)	31	2.85	(.76)	31	.16	-.36
Performance Orientation	2.99	(.75)	31	3.12	(.48)	31	.51	.17

of the attendance subgroup analysis, the total Battelle score and three subdomains being statistically significantly in favor of the less intensive group. Although differences in favor of the expanded intervention group were found in child-related stress, as measured by the PSI, the effect size for the full group analysis is not very different, and this apparent effect is not seen as dramatically in subsequent testing. Tables 2.15 to 2.18 display the results of the subgroup analyses.

Table 2.15

Year 1 Reassessment Measures of Child Functioning for SMA/Lake-McHenry Project (Excluding Subjects with Mild Disabilities)

		Basic Intervention				Expanded Intervention						
Variable	Covariates*	x̄	(SD)	Adj x̄	n	x̄	(SD)	Adj x̄	n	ANCOVA F	ES	P Value
Age in months at Reassessment			24.8	(5.9)	---	21	24.1	(5.2)	16	0.14	-.12	.71
Battelle Developmental Inventory Raw Scores for:												
Personal/Social	1,2,3,4	37.4	(18.5)	39.3	21	37.9	(14.4)	36.0	16	1.38	-.18	.25
Adaptive Behavior	1,2,3,4	28.0	(13.3)	29.6	21	29.9	(10.0)	28.3	16	0.47	-.10	.50
Motor	1,2,3,4	40.6	(26.4)	43.1	21	36.3	(17.8)	33.7	16	4.39	-.36	.04
Communication	1,2,3,4	19.7	(8.9)	20.8	21	21.8	(7.4)	20.7	16	0.00	-.01	.95
Cognitive	1,2,3,4	17.0	(10.0)	18.2	21	19.0	(6.3)	17.8	16	0.11	-.04	.74
Total	1,2,3,4	142.8	(73.9)	151.1	21	144.8	(50.0)	136.5	16	2.55	-.20	.12

* 1 = Battelle Total Raw Score (pretest), 2 = Age of child at pretest, 3 = PSI child related (pretest), 4 = Number of people living in the home

Statistical analysis for assessment instruments was conducted using raw scores for each of the scales.

Table 2.16

Year 1 Reassessment Measures of Family Functioning for Alternative Intervention Groups for SMA/Lake-McHenry (Excluding Subjects with Mild Disabilities)

		Basic Intervention				Expanded Intervention						
Variable	Covariates◆	$\bar{x}$	(SD)	Adj $\bar{x}$	n	$\bar{x}$	(SD)	Adj $\bar{x}$	n	ANCOVA F	ES	p Value
• **Parenting Stress Index***												
Child	1,2	123.5	(18.6)	123.0	21	112.4	(21.5)	112.9	16	3.36	.54	.08
Parent	3,9	131.8	(27.5)	128.9	21	126.6	(35.9)	129.4	16	0.00	-.02	.95
Total	1,2	255.3	(36.5)	250.2	21	239.0	(50.9)	244.1	16	0.26	.17	.62
• **Family Adaptability and** Cohesion Evaluation Scales III (FACES III) - Mother**												
Adaptability	4,6,7	21.0	(4.9)	21.6	21	23.8	(5.0)	23.2	16	0.85	.33	.36
Cohesion	5,3,6,7	38.0	(6.8)	38.2	21	39.1	(5.4)	38.9	16	0.12	.10	.74
• **Family Support Scale (FSS) - Mother**	8,3,6,7	27.3	(9.7)	27.7	21	29.2	(10.9)	28.9	16	0.24	.12	.63

◆ 1 = PSI Total (pretest), 2 = FILE (pretest), 3 = PSI Parent Related (pretest), 4 = FACES adaptability (pretest), 5 = FACES cohesion (pretest), 6 = Father living with child, 7 = Income, 8 = Family Support Scale (pretest)

* Lower scores on the Parent Stress Index are considered better.

** Raw scores for the FACES were used and higher scores are considered better.

Table 2.17

Year 1 Reassessment Measures of Child Functioning for SMA/Lake-McHenry Project (Excluding Subjects with Low Attendance)

		Basic Intervention				Expanded Intervention						
Variable	Covariates◆	$\bar{x}$	(SD)	Adj $\bar{x}$	n	$\bar{x}$	(SD)	Adj $\bar{x}$	n	ANCOVA F	ES	p Value
Age in months at Reassessment		25.3	(6.0)	---	27	21.7	(5.6)	---	20	4.40	-.60	.04
Battelle Developmental* Inventory Raw Scores for:												
Personal/Social	1,2,3,4	57.3	(25.1)	49.9	27	43.2	(15.9)	44.6	20	4.01	-.21	.05
Adaptive Behavior	1,2,3,4	37.4	(16.0)	36.7	27	34.0	(9.5)	34.7	20	1.52	-.13	.23
Motor	1,2,3,4	55.4	(29.3)	54.8	27	44.2	(19.3)	44.8	20	6.17	-.34	.02
Communication	1,2,3,4	27.6	(13.1)	27.2	27	24.6	(7.2)	25.0	20	2.80	-.17	.10
Cognitive	1,2,3,4	23.0	(11.6)	23.0	27	21.4	(5.5)	21.8	20	0.96	-.10	.33
Total	1,2,3,4	195.1	(92.8)	191.6	27	167.3	(51.9)	170.8	20	6.51	-.22	.02

◆ 1 = Battelle Total Raw Score (pretest), 2 = Age of child at pretest, 3 = PSI child related (pretest), 4 = Number of people living in the home

* Statistical analysis for assessment instruments was conducted using raw scores for each of the scales.

Table 2.18

Year 1 Reassessment Measures of Family Functioning for Alternative Intervention Groups for SMA/Lake-McHenry (Excluding Subjects with Low Attendance)

		Basic Intervention				Expanded Intervention						
Variable	Covariates◆	$\bar{x}$	(SD)	Adj $\bar{x}$	n	$\bar{x}$	(SD)	Adj $\bar{x}$	n	ANCOVA F	ES	p Value
• **Parenting Stress Index***												
Child	2,3	120.0	(21.1)	119.1	27	108.3	(16.1)	109.7	20	4.46	.45	.04
Parent	2,7	129.1	(23.8)	126.4	27	127.8	(37.1)	131.4	20	0.78	-.21	.38
Total	1,2	249.1	(38.2)	244.3	27	236.1	(47.4)	242.4	20	0.04	.05	.84
• **Family Adaptability and** Cohesion Evaluation Scales III (FACES III) - Mother**												
Adaptability	4,6	23.2	(6.0)	23.2	27	23.3	(4.5)	22.7	20	0.16	-.08	.69
Cohesion	5,6,7	39.3	(6.8)	39.8	27	38.9	(5.5)	38.1	20	1.21	-.25	.28
• **Family Support Scale (FSS) - Mother**	9,7,8	28.0	(10.0)	28.9	27	31.2	(10.2)	31.0	20	1.15	.21	.29

◆ 1 = PSI Total (pretest), 2 = FILE (pretest), 3 = PSI Child Related (pretest), 4 = FACES adaptability (pretest), 5 = FACES cohesion (pretest), 6 = Maternal age, 7 = PSI Parent Related (pretest), 8 = Occupation of father, 9 = Family Support Scale (pretest)

* Lower scores on the Parent Stress Index are considered better.

** Raw scores for the FACES were used and higher scores are considered better.

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Reassessment Analyses for Year 2

For one subject in the expanded services group, the family declined to have the child complete the measures of child functioning, but did complete the family measures. The results of the analyses of the child functioning measures for the second reassessment for all other subjects are contained in Table 2.19. Once again, all the effect sizes on the Battelle favored the basic group with two subdomains approaching statistical significance (p < .10.).

Table 2.19

Year 2 Reassessment Measures of Child Functioning for Alternative Intervention Groups for SMA/Lake-McHenry

Variable Value	Covariates*	Basic Intervention				Expanded Intervention				ANCOVA F	ES	p
		$\bar{x}$	(SD)	Adj $\bar{x}$	n	$\bar{x}$	(SD)	Adj $\bar{x}$	n			
Average length of time between Reassessments 1 and 2	---	12.9	(1.3)		28	12.6	(1.8,		21	0.79	.13	.38
Age in months at Reassessment 2	---	38.8	(6.4)		28	36.1	(6.7)		21	2.02	.43	.16
• **Battelle Developmental Inventory (BDI) raw scores for:**												
Personal/Social	1,2,3	78.0	(40.7)	79.3	28	74.4	(31.1)	73.1	20	1.79	-.15	.19
Adaptive Behavior	1,2,3	48.0	(25.2)	49.0	28	48.7	(18.4)	47.7	20	0.26	-.05	.61
Motor	1,2,3	62.1	(38.2)	64.3	28	63.0	(26.4)	60.7	20	0.50	-.09	.48
Communication	1,2,3	35.4	(23.2)	35.9	28	30.5	(16.8)	30.0	20	2.78	-.25	.10
Cognitive	1,2,3	28.5	(18.9)	28.8	28	24.8	(12.5)	24.5	20	2.62	-.23	.11
Total	1,2,3	252.0	(140.5)	257.3	28	241.4	(97.1)	236.0	20	2.28	-.15	.14
• **Scales of Independent Behavior:**												
Early Development Standard Score	3,4,5	54.1	(35.0)	53.8	27	53.6	(32.4)	53.8	20	.00	.00	.99

* 1 = Battelle total raw score (pretest), 2 = Age of child at pretest, 3 = PSI child related (pretest), 4 = Battelle adaptive behavior raw score (pretest), 5 = Number of people living in the home

Statistical analysis for assessment instruments was conducted using raw scores for each of the scales.

The results of the analyses of the second reassessment measures of family functioning are contained in Table 2.20. There was a statistically significant difference between the groups for Mother's Family Support Scale Score for adequacy of support. This is consistent with the findings for the first reassessment.

Table 2.20

Year 2 Reassessment Measures of Family Functioning for Alternative Intervention Groups for SMA/Lake-McHenry

Variable	Covariates◆	Basic Intervention $\bar{x}$	Basic Intervention (SD)	Basic Intervention Adj $\bar{x}$	Basic Intervention n	Expanded Intervention $\bar{x}$	Expanded Intervention (SD)	Expanded Intervention Adj $\bar{x}$	Expanded Intervention n	ANCOVA F	ES	P Value
• **Parenting Stress Index***												
Child	1,2	121.6	(23.8)	121.8	28	114.3	(26.3)	114.1	21	2.16	.32	.15
Parent	1,2	132.1	(26.8)	131.0	28	135.1	(40.2)	136.2	21	0.52	-.19	.47
Total	1,2	253.7	(45.9)	252.8	28	249.4	(62.0)	250.3	21	0.06	.05	.81
• **Family Adaptability and** Cohesion Evaluation Scales III (FACES III) - Mother**												
Adaptability	3	20.9	(4.9)	21.1	28	19.5	(6.2)	19.3	21	1.26	.37	.27
Cohesion	2,4,5,7	37.8	(6.4)	37.9	28	38.2	(6.4)	38.0	21	0.00	-.02	.96
• **Family Support Scale (FSS) - Mother**	1,6	25.0	(9.1)	25.0	28	29.4	(10.7)	29.8	21	4.83	.53	.03
• **Comprehensive Evaluation of* Family Functioning-Mother**												
Total Frequency	1,8	93.7	(27.9)	93.5	27	95.3	(19.8)	95.4	19	0.16	-.07	.69
Total Problems	1,8	7.3	(7.9)	7.5	26	8.1	(9.6)	7.8	19	0.03	-.04	.86
• **Comprehensive Evaluation of* Family Functioning-Father**												
Total Frequency	1,8	91.4	(25.7)	93.1	18	96.1	(16.2)	94.4	16	0.06	-.05	.81
Total Problems	1,8	6.4	(6.9)	6.7	18	7.7	(9.6)	7.3	15	0.05	-.09	.82

◆ 1 = PSI Total (pretest), 2 = Maternal age, 3 = FACES Adaptability (pretest), 4 = FACES cohesion (pretest), 5 = Family resource scale (pretest), 6 = Family Support scale (pretest), 7 = PSI other related (pretest), 8 = Battelle total raw score (pretest)

* Lower scores on the Parent Stress Index are considered better.

** Raw scores for the FACES were used and higher scores are considered better.

Lower scores for Total Problems are considered better, while high scores on total frequency are considered better.

Reassessment Analyses for Year 3

There were no statistically significant differences between the groups on any measures of child functioning (Table 2.21) in favor of the expanded services group at the third reassessment. Once again, all effect sizes were negative with three subdomains of the Battelle and the total score being statistically significantly in favor of the basic intervention group. On the measures of family functioning (Table 2.22), there was still a statistically significant difference on the Family Support Scale. There were no other statistically significant differences between the groups on any of the other family measures.

Table 2.21

Year #3 Reassessment Measures of Child Functioning for Alternative Intervention Groups for SMA/Lake McHenry

		Basic Intervention				Expanded Intervention						
Variable	Covariates◆	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	ANCOVA F	ES	P Value
• Time Between Reassessment #2 and #3		13.1	(2.0)	---	22	13.1	(1.7)	---	16	0.00	.00	.98
• Age in Months at Reassessment #3		53.1	(6.3)	---	22	49.4	(6.4)	---	16	3.16	-.59	.08
• **Battelle Developmental Inventory**												
Raw Scores for:												
Personal/Social	1,2,3	98.4	(43.9)	99.2	22	81.3	(34.1)	80.6	16	6.11	-.42	.02
Adaptive Behavior	1,2,3	59.3	(27.8)	59.2	22	54.6	(19.9)	54.8	16	1.05	-.16	.31
Motor	1,2,3	82.5	(48.9)	81.9	22	78.2	(32.8)	78.8	16	0.20	-.06	.66
Communication	1,2,3	49.8	(29.8)	49.3	22	34.3	(18.4)	34.8	16	6.84	-.49	.01
Cognitive	1,2,3	43.9	(27.2)	43.2	22	32.8	(15.4)	33.4	16	5.28	-.36	.03
Total Score	1,2,3	334.0	(170.6)	332.8	22	281.2	(113.6)	282.4	16	4.47	-.30	.04
• **Child Behavior Checklist**												
T-Score - Internalizing	---	54.7	(8.3)	---	22	54.6	(9.2)	---	15	0.00	.01	.97
T-Score - Externalizing	---	48.5	(10.3)	---	22	51.9	(13.5)	---	15	0.76	-.33	.39
T-Score - Total Problems	---	50.6	(10.3)	---	22	52.5	(11.3)	---	15	0.28	-.18	.60

◆ 1 = Battelle total raw score (pretest), 2 = Age of child at pretest, 3 = PSI child related (pretest).

Statistical analysis for assessment instruments was conducted using raw scores for each of the scales.

Table 2.22

Year #3 Reassessment Measures of Family Functioning for Alternative Intervention Groups for SMA/Lake McHenry

		Basic Intervention				Expanded Intervention						
Variable	Covariates◆	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	ANCOVA F	ES	p Value
• **Parenting Stress Index**·												
Child	1,2,3	114.0	(24.0)	117.1	22	115.4	(30.1)	112.9	16	0.38	.18	.55
Parent	1,2,3	124.3	(24.2)	128.4	22	137.1	(44.2)	134.5	16	0.62	-.25	.44
Total	1,2,3	238.3	(45.9)	238.8	22	253.2	(68.1)	252.5	16	0.03	-.05	.85
• **FACES III - Mother**··												
Adaptability	2,4	21.9	(4.1)	22.1	22	21.5	(6.9)	21.1	16	0.37	.24	.55
Cohesion	2,5	38.6	(7.4)	38.0	22	38.4	(6.0)	39.0	16	0.27	-.14	.61
• **Family Support Scale-Mother**	1,6	25.3	(11.3)	24.9	22	30.2	(11.6)	30.7	16	3.90	.51	.06
• **Comprehensive Evaluation of**· **Family Functioning**-Mother												
Total Frequency	1	92.9	(17.6)	92.4	20	91.2	(26.3)	91.6	14	0.02	.05	.90
Total Problems	1	5.3	(6.9)	5.0	20	6.9	(9.7)	7.1	14	0.76	-.30	.39
• **Comprehensive Evaluation of**· **Family Functioning**-Father												
Total Frequency	1	94.4	(16.3)	95.2	15	98.1	(15.1)	97.3	14	0.15	-.13	.70
Total Problems	1	5.6	(6.1)	5.9	15	4.9	(5.6)	4.6	14	0.41	.21	.53

◆ 1 = PSI total (pretest, 2 = FILE (pretest), 3 = Number of siblings receiving special education services, 4 = FACES adaptability (pretest), 5 = FACES cohesion (pretest), 6 = Family support scale (pretest)

· Lower scores on the Parent Stress Index are considered better.

·· Raw scores for the FACES were used and higher scores are considered better.

Lower scores for Total Problems are considered better, while high scores on total frequency are considered better.

The data from the teacher questionnaire (Table 2.23) indicated that there were no statistically significant differences between the groups in terms of current educational placement on time spent in various types of classrooms. The data presented in this table indicate that the large majority of these subjects are currently receiving special education services, or more hours per day, in a self-contained special education classroom.

Table 2.23

Year #3 Reassessment Teacher Ratings and Parent Satisfaction Data for Alternative Intervention Groups for SMA/Lake McHenry

Variable	Basic Intervention			Expanded Intervention			ANOVA	p	
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	F	Value	ES
• Percentage of subjects currently in special education	90		20	100		15		.45	.25
• Percentage with 90-100% Attendance◆	85		20	71		14		.37	-.30
• Teacher's recommendation for◆ placement for next year	1.9	(1.6)	18	1.6	(1.1)	15	0.73	.47	-.19
• Teacher ratings for 15 items◆	36.1	(5.3)	20	37.9	(4.5)	15	1.16	.29	.34
• # of months child has attended current program	16.6	(7.8)	18	14.4	(9.5)	15	0.51	.48	-.28
• # of Hours/Wk child attends current program	16.8	(9.9)	18	15.3	(7.9)	15	0.24	.63	-.15
• % of time per week child spends in regular class	7.5	(24.5)	20	4.0	(15.5)	15	0.24	.63	-.14
• % time per week child is in· self-contained class	82.4	(32.3)	20	92.4	(22.9)	14	0.98	.33	.31

◆ Higher scores for teacher recommendations indicate greater involvement in regular education program. Higher scores for teacher ratings indicate more desirable functioning.

· Lower percentage is considered better.

NOTE: Effect sizes from percentages were computed from a t statistic after an additional subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

Reassessment Analysis for Year 4

Results from Year 4 do not disagree with previous years' results. Again, all differences between groups favored the basic services group on child functioning (Table 2.24). This reassessment, however, showed no statistically significant differences in any domain of the Battelle or its total. Statistically significant differences were found, however, on one subscale and the total score of the PSI (Table 2.25). This indicates that families of the expanded services group had lower overall stress and stress related to their daily lives and parenting roles.

Table 2.24

Year #4 Reassessment Measures of Child Functioning for Alternative Intervention Groups for SMA/Lake McHenry

		Basic Intervention				Expanded Intervention						
Variable	Covariates◆	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES
Age in months at Reassessment												
Battelle Developmental· Inventory Raw Scores for:												
Personal/Social	1,2,3,4,5	115.7	(45.2)	112.7	20	105.2	(40.0)	105.8	18	0.35	.56	-.15
Adaptive Behavior	1,2,3,4,5	72.2	(29.0)	69.6	20	65.3	(23.9)	66.3	18	0.26	.61	-.11
Motor	1,2,3,4,5	96.9	(49.3)	95.0	20	90.5	(37.3)	89.3	18	0.29	.59	-.12
Communication	1,2,3,4,5	61.5	(32.6)	61.1	20	47.7	(24.2)	46.8	18	2.71	.11	-.44
Cognitive	1,2,3,4,5	56.8	(32.7)	55.8	20	43.4	(23.3)	42.8	18	2.57	.12	-.40
Total	1,2,3,4,5	403.4	(183.0)	394.3	20	352.1	(138.6)	351.0	18	1.14	.30	-.24

◆ 1 = Battelle Total Raw Score (pretest), 2 = Age of child at pretest, 3 = PSI child related (pretest), 4 FILE (pretest), 5 = Number of people living in the home.

Statistical analysis for assessment instruments was conducted using raw scores for each of the scales.

Table 2.25

Year #4 Reassessment Measures of Family Functioning for Alternative Intervention Groups for SMA/Lake McHenry

		Basic Intervention				Expanded Intervention						
Variable	Covariates◆	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES
• **Parenting Stress Index·**												
Child	1,2,3	109.1	(25.0)	116.2	17	108.5	(30.3)	102.8	16	2.34	.14	.54
Parent	1,2,3	122.5	(22.3)	132.3	17	126.8	(41.1)	118.4	16	3.69	.07	.62
Total	1,2,3	231.5	(42.7)	248.5	17	235.3	(68.0)	221.2	16	3.79	.06	.64
• **Family Adaptability and·· Cohesion Evaluation Scales III (FACES III) - Mother**												
Adaptability	4,6	22.5	(5.0)	22.3	19	21.2	(5.4)	21.7	17	0.15	.71	-.12
Cohesion	5,7,6,8,2	40.6	(4.2)	38.9	19	39.4	(8.4)	40.6	17	0.83	.37	.40
• **Family Support Scale (FSS) - Mother**	9,2	30.4	(8.6)	28.7	19	28.8	(9.2)	30.7	17	0.42	.52	.23
• **Comprehensive Evaluation of^ Family Functioning--Mother**												
Total Frequency	1	91.8	(19.8)	94.0	16	88.8	(26.4)	86.6	17	0.92	.35	-.37
Total Problems	1	6.8	(7.5)	8.0	16	6.0	(10.3)	4.8	17	1.57	.22	.43

◆ 1 = PSI Total (pretest), 2 = FILE (pretest), 3 = Ethnicity of child (Caucasian/noncaucasian), 4 = FACES adaptability (pretest), 5 = FACES cohesion (pretest), 6 = Age of child at pretest, 7 = PSI other related (pretest), 8 = Family Resource Scale (pretest), 9 = Family support scale (pretest).

· Lower scores on the Parent Stress Index are considered better.

·· Raw scores for the FACES were used and higher scores are considered better.

^ Lower scores for Total Problems are considered better, while high scores on Total frequency are considered better.

Reassessment Analysis for Year #5

Without exception, both in child and family functioning measures, analyses from the fifth reassessment indicated that no statistically significant differences between groups existed. Tables 2.26 and 2.27 show the results of this analysis.

Table 2.26

Year #5 Reassessment Measures of Child Functioning for Alternative Intervention Groups for SMA/Lake McHenry

		Basic Intervention				Expanded Intervention						
Variable	Covariates♦	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	ANCOVA F	p Value	ES
Battelle Developmental Inventory Raw Scores for:												
Personal/Social	1,2,3,4	117.8	(54.6)	120.2	24	119.5	(52.0)	117.2	25	0.09	.77	-.05
Adaptive Behavior	1,2,3,4	77.3	(32.4)	78.4	24	73.8	(31.2)	72.7	25	0.97	.33	-.18
Motor	1,2,3,4	105.7	(51.1)	108.7	24	100.0	(46.3)	97.1	25	1.51	.23	-.17
Communication	1,2,3,4	70.0	(38.8)	71.2	24	64.3	(36.4)	63.1	25	1.08	.31	-.18
Cognitive	1,2,3,4	63.8	(37.8)	64.9	24	61.0	(34.1)	59.9	25	0.47	.50	-.13
Total	1,2,3,4	434.8	(208.0)	443.4	24	418.6	(191.9)	410.0	25	0.83	.37	-.16
Social Skills Rating System (Teacher)^												
Social Skills	4,7	32.6	(14.2)	30.6	20	29.5	(14.8)	31.5	23	0.05	.82	.06
Problem Behaviors	5	9.1	(4.5)	9.2	18	10.1	(5.4)	10.0	22	0.23	.65	-.17
Academic Competence	2,4,6,7	27.6	(10.5)	27.5	21	27.2	(9.4)	27.3	23	0.00	.96	-.01

♦ 1 = Battelle Cognitive Raw Score (pretest), 2 = Age of child at pretest, 3 = PSI child related (pretest), 4 = Number of people living in the home, 5 = Family Resource Scale (Pretest), 6 = Maternal age, 7 = Battelle Total Raw Score (pretest)

Statistical analysis for assessment instruments was conducted using raw scores for each of the scales.

Table 2.27

Year #5 Reassessment Measures of Family Functioning for Alternative Intervention Groups for SMA/Lake McHenry

		Basic Intervention				Expanded Intervention						
Variable	Covariates♦	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	ANCOVA F	p Value	ES
• **Family Support Scale (FSS) - Mother**	1,2	28.8	(9.0)	29.2	24	30.6	(9.0)	30.2	25	0.15	.70	.11
• **Comprehensive Evaluation of Family Functioning--Mother**^												
Total Frequency	1,6	83.7	(31.4)	83.9	23	87.2	(27.2)	86.9	25	0.17	.69	.10
Total Problems	1	5.3	(7.7)	5.3	23	6.5	(9.2)	6.5	23	0.29	.59	-.15
• Parent Self-Awareness Scale	3,4,5	43.5	(8.0)	42.6	22	43.7	(8.1)	44.6	23	1.09	.30	.25

♦ 1 = PSI Total (pretest), 2 = Child age at pretest, 3 = FACES cohesion (pretest), 4 = Family resource scale (pretest, 5 = PSI other related (pretest), 6 = Battelle total raw score (pretest)

^ Lower scores for Total Problems are considered better, while high scores on Total Frequency are considered better.

Reassessment Analysis for Year #6

Results from Year 6 again indicate that there are no significant differences between groups on the BDI. The results of the Woodcock-Johnson are not presented here because too many subjects failed to reach baseline. The results of the Pictorial Scale of Perceived Competence echoes the results of the BDI, with all effect sizes being nonsignificant.

Results from the SSRS show different opinions between teacher and parent concerning the social skills of the subject children. The results from the mothers indicate that children from the basic intervention group show significantly fewer negative behaviors, but in general, show similar social skills. Results from the teachers indicate that the children from the basic intervention group showed better social skills and fewer problem behaviors. Additionally, academic competence parallels the results of the developmental measures.

Results from the family measures show consistent differences between groups for the subscales and the total score of the PSI. This may indicate that the parents of children in the more intensive group suffer from less stress related to their child, related to interactions with their child, and overall parenting. Tables 2.28 and 2.29 show the results of this analysis.

Table 2.28

Year #6 Reassessment Measures of Child Functioning for Alternative Intervention Groups for SMA/Lake McHenry

Variable	Covariates◆	Basic Intervention $\bar{x}$	Basic Intervention (SD)	Basic Intervention Adj.$\bar{x}$	Basic Intervention n	Expanded Intervention $\bar{x}$	Expanded Intervention (SD)	Expanded Intervention Adj.$\bar{x}$	Expanded Intervention n	ANCOVA F	p Value	ES
Battelle Developmental^ Inventory Raw Scores for:												
Personal/Social	1,2	118.1	(57.3)	122.5	19	120.9	(58.0)	116.4	23	.21	.65	-.11
Adaptive Behavior	1,2	79.4	(38.3)	82.5	19	78.6	(36.3)	75.6	23	.84	.37	-.18
Motor	1,2	110.2	(56.6)	115.1	19	104.3	(50.4)	99.4	23	2.72	.11	-.28
Communication	1,2	73.4	(43.6)	76.6	19	70.7	(39.0)	67.5	23	.95	.34	-.21
Cognitive	1,2	67.4	(42.3)	70.3	19	66.3	(38.0)	63.4	23	.61	.44	-.16
Total	1,2	448.8	(234.0)	467.4	19	440.8	(216.3)	422.2	23	.94	.34	-.19
Social Skills Rating System (parent)												
Social	1,3	81.6	(25.0)	81.5	18	79.9	(23.8)	80.0	19	.03	.86	-.06
Behaviors	1,3	104.3	(19.2)	109.4	17	94.7	(17.4)	89.6	19	10.49	.00	-1.03
Social Skills Rating System (Teacher)												
Social	1,3	95.5	(20.7)	98.2	13	87.4	(25.3)	84.6	16	2.41	.13	-.66
Behavior	1,3	104.2	(12.8)	105.1	13	100.3	(12.3)	99.4	16	1.26	.27	-.45
Academic Competence	1,3	95.5	(17.7)	97.1	12	87.6	(17.4)	86.0	17	2.55	.12	-.63
The Pictorial Scale of Perceived Competence												
Cognitive Competence	1,2	21.1	(1.8)	21.3	11	21.2	(2.3)	21.0	10	.10	.76	-.17
Peer Acceptance	1,2	14.1	(4.5)	14.1	11	14.5	(2.6)	14.5	10	.06	.81	.09
Physical Competence	1,2	18.6	(4.2)	19.0	11	16.8	(5.4)	16.5	10	1.93	.18	-.60
Maternal Acceptance	1,2	15.7	(4.2)	15.8	11	17.0	(4.1)	16.9	10	.30	.59	.26

◆ 1 = Battelle Total Raw Score (pretest), 2 = Age of child at pretest, 3 = Family Resource Scale (pretest)

^ Statistical analysis for assessment instruments was conducted using raw scores for each of the scales.

Table 2.29

Year #6 Reassessment Measures of Family Functioning for Alternative Intervention Groups for SMA/Lake McHenry

Variable	Covariates♦	Basic Intervention				Expanded Intervention				ANCOVA F	p Value	ES
		x̄	(SD)	Adj.x̄	n	x̄	(SD)	Adj.x̄	n			
• **Family Support Scale (FSS) - Mother**	1,2,3	27.4	(10.6)	25.9	19	31.0	(13.6)	32.5	21	2.03	.16	.62
• **Parent Stress Index Short Form^**												
Parent	1,2	27.8	(8.2)	29.8	19	28.2	(10.3)	26.2	20	1.19	.28	.44
Parent-Child	1,2	26.1	(8.9)	27.1	19	23.5	(5.6)	22.4	20	2.89	.10	.53
Child	1,2	31.8	(10.7)	33.0	19	29.0	(9.2)	27.8	20	2.01	.17	.49
TOTAL	1,2	85.1	(24.00	89.0	19	80.6	(21.3)	76.6	20	2.30	.14	.52
• Parent Self-Awareness Scale	1,2	44.7	(7.0)	42.1	19	41.6	(8.5)	44.2	20	.73	.40	.30

♦ 1 = Battelle Total Raw Score (pretest, 2 = Family Resource Scale (pretest), 3 = Family Support Scale (pretest)

^ Lower scores for Total Problems are considered better, while high scores on Total Frequency are considered better.

Table 2.30

Year #7 Reassessment Measures of Child Functioning for Alternative Intervention Groups for SMA/Lake McHenry

Variable	Covariates♦	Basic Intervention				Expanded Intervention				ANCOVA F	p Value	ES
		x̄	(SD)	Adj.x̄	n	x̄	(SD)	Adj.x̄	n			
Woodcock-Johnson Test of Achiev.												
Broad Knowledge	1,2	478.1	(17.9)	475.9	7	464.7	(26.4)	467.0	10	.70	.42	-.50
Skills	1,2	458.9	(32.2)	454.5	7	424.8	(45.9)	429.2	10	1.91	.19	-.79
Scales of Independent Behavior												
Motor Skills	1,2	400.4	(74.8)	408.4	12	414.1	(60.4)	406.2	15	.02	.90	-.03
SocialCommunication	1,2	442.3	(37.1)	444.9	12	438.5	(43.00	435.9	15	.66	.42	-.24
Personal Living	1,2	433.1	(48.2)	435.4	12	437.8	(43.4)	435.5	15	.00	.99	.00
Community Living	1,2	430.9	(46.4)	431.9	12	417.6	(45.9)	416.6	15	1.50	.23	-.33
Broad Independence	1,2	426.8	(48.9)	430.0	12	426.3	(45.4)	423.0	15	.37	.55	-.14
Social Skills Rating System (parent)												
Skill Total	1,3	75.5	(23.0)	73.4	12	72.8	(26.1)	75.0	13	.04	.84	.07
Problem Behaivors	1,3	100.8	(18.2)	102.9	12	101.0	(9.8)	98.9	13	.36	.56	.22
SocialSkills Rating System (teacher)												
Skill Total	1,3	103.5	(19.0)	102.0	13	77.8	(19.5)	79.2	9	6.94	.02	-1.20
Problem Behaviors	1,3	97.5	(12.8)	97.4	13	105.8	(9.0)	105.9	9	2.28	.15	-.66
Academic Competence	1,3	98.0	(18.0)	96.1	13	79.4	(14.7)	81.3	9	5.19	.04	-.82
The Pictorial Scale of Perceived Competence												
Cognitive Competence	1,2	21.7	(1.9)	22.0	6	18.3	(7.9)	17.9	8	1.93	.20	-2.16
Peer Acceptance	1,2	14.8	(6.9)	14.8	6	12.6	(5.4)	12.7	8	.52	.49	-.30
Physcial Competence	1,2	18.8	(4.0)	18.6	6	15.1	(7.6)	15.3	8	1.19	.30	-.83
Maternal Acceptance	1,2	14.7	(5.0)	14.9	6	13.1	(6.4)	12.8	8	.40	.54	-.42

♦ 1 = Battelle Total Raw Score (pretest), 2 = Age of child at pretest, 3 = Family Resource Scale (pretest)

^ Statistical analysis for assessment instruments was conducted using raw scores for each of the scales.

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Table 2.31

Year #7 Reassessment Measures of Family Functioning for Alternative Intervention Groups for SMA/Lake McHenry

		Basic Intervention				Expanded Intervention						
Variable	Covariates♦	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES
• **Family Support Scale (FSS) - Mother**	1,2,3	28.6	(11.2)	26.1	12	31.5	(14.5)	34.1	13	2.14	.16	.71
• **Parent Stress Index Short Form**												
Parent	1,2	26.9	(9.1)	30.1	12	30.7	(13.5)	27.5	13	.31	.58	.29
Parent-Child	1,2	23.9	(7.8)	25.2	12	24.0	(6.3)	22.7	13	.77	.39	.32
Child	1,2	30.5	(11.0)	32.3	12	31.2	(9.9)	29.3	13	.46	.51	.27
TOTAL	1,2	81.3	(22.1)	87.6	12	85.8	(27.9)	79.5	13	.66	.43	.37
• **Parent Self-Awareness Scale**	1,2	44.6	(13.9)	39.8	12	46.5	(12.8)	51.3	13	6.08	.02	.83

♦ 1 = Battelle Total Raw Score (pretest, 2 = Family Resource Scale (pretest), 3 = Family Support Scale (pretest)

^ Lower scores for Total Problems are considered better, while high scores on Total Frequency are considered better.

Reassessment Analysis for Year #7

Preliminary results from Year 7 show very similar results to previous years. Scores from the Woodcock-Johnson and the SIB were higher for the basic intervention group. The only statistically significant results occurred on the teacher form of the SSRS. In both cases, the basil intervention group showed higher standard scores. Sample sizes for both the Pictorial Scale of Perceived Competence and the Woodcokc-Johnson were low due to number subjects functioning too low to respond to the test items.

Results from the family functioning measures were all in favor of the expanded intervention group. Results of the Parent Self-Awareness Scale were statistically significant. It should be noted that this testing cycle is not complete and differences displayed here may disappear on final analysis.

Conclusions

A few conclusions can be made about the relative effectiveness of once per week versus three times per week services given the longitudinal data presented for this population. First of all, it does not appear that increasing the number of service hours to three times a week has a significant effect on the skill development of a child with disabilities. Although there were three separate indices of the child's developmental level at Years 1, 6, and 7 two indices at Year 2, 3 and 5, and one at Year 4, there were no statistically significant differences between the once-per-week and three-times-per-week groups on any of these measures in favor the expanded services group for any of the complete assessments.

In fact, all differences in child functioning, with the exception of the Wisconsin at the first reassessment and an occassional domain of the SSRS, were in favor of the basic intervention group. This does not necessarily indicate that less intensive interventions are better, but with all the data suggesting that treatment was implemented as planned, and that groups remained comparable for all 7 reassessment analyses, it is fairly certain that this small increase in service intensity failed to produce detectable benefits in terms of child functioning.

The only benefit for families is the perception that they are receiving better support, which is worthwhile, but may not be worth an expenditure of approximately $6,500 per child per year. Even though the data from this study are clear, it should be noted that final decisions should not be made until other studies replicate these results. It is also important to note that this does not necessarily mean that more intensive interventions will not be more effective. There may well be a threshold which has not been achieved in this study. Perhaps instead of providing three hours of individualized intervention per week, 20 hours per week are necessary to achieve the types of benefits that would be measurable. Additionally, the hypothesis that the observed effects on parental support might generalize to more profound outcomes such as a maintenance of parental marital status and willingness of the family to continue to maintain the child in the home. Finally, measures of child functioning become more reliable as the subjects get older, and thus may reveal differences in school achievement or competence. Therefore, the longitudinal data to be collected in future years will be crucial in addressing these issues.

ARKANSAS INTENSITY STUDY

Project #3

COMPARISON: Children with Mild to Severe Disabilities--Home-based intervention once per week versus home-based intervention twice per week.

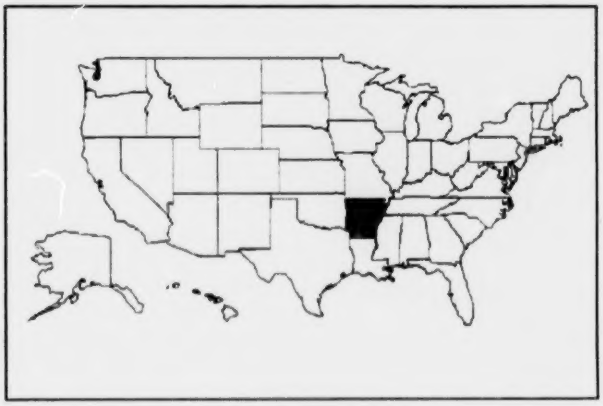
LOCAL CONTACT PERSONS: Lowell Collins, Coordinator (Sunshine Preschool)

EIRI COORDINATORS: William Eiserman and Lenore Shisler

LOCATION: Bentonville, Arkansas; and Fayetteville, Arkansas

DATE OF REPORT: November 4, 1994

Rationale for the Study



Limited evidence in the existing literature is available to guide programming decisions concerning the relative effectiveness of various intensities of early intervention (White & Casto, 1985). The frequency and intensity with which early intervention services are provided varies across program models based largely on philosophical orientation and professional judgment of individual child needs. Although home-based early intervention models are widely used, there is little empirical evidence upon which to make decisions regarding the effects of varying the frequency of home-based services. This study provides a comparison of the effectiveness of two levels of intensity of home-based services for children from birth to five years old.

Review of Related Research

Because of the passage of Public Law 99-457, state legislators and personnel in state educational, health, and social service agencies have devoted increased attention to providing educational and supportive services to birth to five-year-old children with disabilities and their families. One of the most frequent questions asked by those responsible for designing early intervention programs is how frequently services should be delivered. Most people associated with early intervention assume that more frequent services will result in greater benefits for participating children and their families (e.g., Bryant & Ramey, 1987; Dunst, Snyder, & Mankinen, 1989). Because more frequent services are likely to be more expensive; however, program administrators are hesitant to increase the frequency of services, unless there is evidence that such an increase will be beneficial for participating children and families.

Surprisingly, only a few studies have directly examined the issue of whether services that are delivered more frequently to children who are disabled will result in greater gains. Even more surprising is the fact that what little research has been done on this topic, particularly that which is methodologically well-designed and well-implemented, has yielded conclusions that are contrary to what most people expect. For example, Sandow and her colleagues compared a home visit program in which children with disabilities were visited two times per month versus the same program provided once every two months (Sandow & Clarke, 1978; Sandow, Clark, Cox, & Stewart, 1981). Differences in cognitive functioning were not statistically significant after one, two, or three years. Similar findings of no differences for children who were motor impaired have been reported by Jenkins et al. (1982) who examined the effects of early intervention for a group of children who received three home visits per week and a group that was visited once per week (average effect size

= .08); and by Law et al. (1991) who compared the effects of a three to one ratio of home visits and parent-delivered therapies (average effects size = 0.0).

For center-based early intervention programs with children who have disabilities, the results have been similar, but not as consistent. Taylor, White, and Pezzino (1984) and Barnett and Pezzino (1987) found no statistically significant differences in two studies which compared half-day versus full-day early intervention programs (average effect sizes for the two studies were .10 and -.11, respectively). Lovass (1987), on the other hand, reported substantial and statistically significant differences for a group of autistic children who received 40 hours per week of one-to-one services compared to another group of autistic children who received only 10 hours per week of intervention (average effect size = 1.41).

In summary, even though most people assume that children with disabilities who receive more frequent early intervention services will benefit (see, for example, reviews by Bryant & Ramey, 1987; Casto & Mastropieri, 1986; Dunst et al., 1989; Horowitz & Paden, 1973; and White et al., 1985-86), the research cited above, all of which is from well-designed studies, is very thin and usually yields findings that are contrary to expectations. (For a more extensive discussion of research on the effects of varying the intensity of early intervention, see Innocenti & White, 1992). The need for additional research on the relationship between frequency of intervention and outcomes, has been emphasized by virtually all who have worked in the area (e.g., Bailey & Simeonsson, 1988; Casto & Mastropieri, 1986; Jenkins et al., 1982; Law et al., 1991; White et al., 1985-86).

Overview of Study

Children and families in this study were randomly assigned to participate in either a standard or an expanded home-based level of intervention. Additional center-based services such as occupational, physical, and speech therapy were available at comparable intensities to children in both groups. Expanded services were funded collaboratively (through the efforts of the service providers and EIRI) for the 1986-87 and 1987-88 academic years.

All children and parents completed a battery of tests (prior to, during, and following the interventions) that measured the child's developmental status, family demographics, parental stress, sources of support, and family adaptability and cohesion. Enrollment in the study was conducted during two academic years (1986-87 and 1987-88), resulting in two cohorts of participating subjects. Each cohort was subsequently administered reassessments at the following intervals: 8 months, 18 months, 30 months and 42 months following enrollment to intervention services (see Table 3.1). Additionally, Cohort 1 was followed and reassessed at 66 months, 78 months, and 90 months. This report summarizes the first six reassessments and introduces the 90-month reassessment of the first cohort.

Methods

Program Organization

At the time this study was conducted, the Sunshine Preschool and Richardson Center were funded under the Arkansas Developmental Disabilities Council to serve individuals with disabilities not being assisted by the public schools due to either age or severity of disability. The elements of the programs related to this research were administered by on-site coordinators who managed the research. The Sunshine program served children from birth to school-age, and the Richardson Center served persons from birth to adulthood; at the preschool level, both centers had home-based programs for children birth to three and center-based programs for children three to five. The Sunshine program also provided home-based services to children three to five when transportation to the center could not be arranged. Both Sunshine and Richardson Centers had as their main service goal for preschoolers to develop

Table 3.1

Number of Children Tested by Test Date, Group, Cohort, and Site

	Pretest Year		Reassessment Session						
	1986-1987	1987-1988	8-Month 1987-1988	18-Month 1988-1989	30-Month 1989-1990	42-Month 1990-1991	66-Month 1991-1992	78-Month 1992-19931	90-Month 1993-1994
COHORT #1									
Standard Service									
* Sunshine	22	--	20	16	15	19	14	13	14
Richardson	5	--	4	4	3	3	4	4	3
Expanded Service									
Sunshine	24	--	23	20	21	21	23	23	19
Richardson	7	--	5	7	6	6	6	6	6
Total Sunshine	46		43	36	36	40	37	36	33
Total Richardson	12		9	11	9	9	10	10	9
Cohort # 1	58		52	47	45	49	47	46	42
COHORT #2									
Standard Service									
Sunshine	--	6	2	3	3	20			
Richardson	--	4	3	3	1	0			
Expanded Service									
Sunshine	--	7	7	5	5	3			
Richardson	--	3	3	3	2	3			
Total Sunshine		13	9	8	8	5			
Total Richardson		7	6	6	3	3			
Cohort # 2		20	15	14	11	8			

* Services were provided by two early intervention centers; the Sunshine School and the Richardson Center.

functional, generalizable skills that enhanced development. Both centers transitioned some children into public school special education programs and continued to provide school-age services to the children with the most severe disabilities.

Prior to the initiation of the research, the Richardson Center program was entirely center-based, serving children on a schedule that was agreed upon by parents and center staff. Because of serious attendance problems, staff were not satisfied that the center-based delivery system was the most effective system available for serving these young children. They looked to the Sunshine Center as a model for home-based delivery. When the director of the Richardson Center decided to adopt a home-based model, she was invited to participate in the research. The staff at the Richardson Center were then trained and evaluated by the Sunshine Preschool coordinator. The Richardson Center had a staff of approximately 30 professionals and paraprofessionals. Two home-teachers, a speech therapist, and a physical therapist were involved in serving the children in the study.

With the help of staff at EIRI, funds were identified and obtained to enable the directors of both the Sunshine Preschool and the Richardson Center to offer twice-per-week home-based services on a short-term basis (two years) for a limited number of children. Without these funds, the standard level of once per week or once every other week would have been provided to all children.

Subjects

Subjects were from 3 to 48 months of age at time of enrollment and were eligible for early intervention services according to Arkansas Developmental Disabilities Division standards. Parents of each child who met the study criteria were invited to participate and then were randomly assigned to either the standard frequency group (approximately 1 time per week) or the expanded intervention group (approximately 2 times per week). Approximately 6% of the invited families declined to participate in the research and continued to receive the standard level of intervention.

Children qualified for participation in the research on the basis of their age, type, and severity of disability. Children were only enrolled in the research if they were eligible for at least one more academic year of early intervention prior to entering kindergarten. Since children were randomly assigned to treatments in this study, previously received interventions were balanced between the groups. All children were assessed using the Developmental Profile II (Alpern, Boll, & Shearer, 1980). Any children who could complete 75% of items at his/her age range were excluded from the study.

Recruitment. All families with children receiving services prior to the 1986-87 academic year, and all new referrals during that year and the Fall of the 1987-88 year were approached by personnel from the Benton County Sunshine Preschool or the Richardson Center for possible participation in the study. Of those approached, all but 5 (2 at the Sunshine program and 3 at the Richardson Center) agreed to participate. This represents a 94% (78 of 83) rate of participation.

Assignment to groups. A total of 78 children met the preceding criteria for inclusion in the study and were subsequently stratified into three age levels (birth to 20 months; 21 to 36 months; and 36 to 48 months) and three levels of disability (severe [< 25% of age level]; moderate [25 to 50% of age level]; and mild [51 to 75% of age level on the Developmental Profile]). Within each cell children were then randomly assigned to the standard or the expanded intervention group. A complete description of assignment procedures is provided in the 1987 Annual Report of the Early Intervention Effectiveness Institute.

Attrition. Sixty-seven children from both cohorts were reassessed 8 months after the pretest, 61 children after 18 months, 56 children after 30 months, and 57 children after 42 months (see Table 3.1). A total of 47 children from cohort 1 completed the 66-month reassessment in 1992, 46 children completed the 78-month reassessment in 1993 and 42 children completed the 90-month reassessment in 1994 (data for one subject was received after the analysis was completed for this report and will be involved in a later update). The number of children not participating at each reassessment and the reasons for non-participation are presented in Table 3.2. Parents who refused further participation in the study did so because their children were already receiving developmental assessments at school and because they were concerned that their children were being tested too much. One family at the Richardson Center refused because they felt the family measures were too intrusive. A major cause of attrition at the Sunshine Preschool was difficulty in locating families at the time of reassessment. These were primarily families that moved frequently and did not have telephones. Reanalysis of the original treatment verification data, conducted prior to the 90-month reassessment, showed that five subjects in the study had actually participated in the study for less than 6 months. It was determined that these subjects should be considered attrited and should no longer be included in the study.

Analyses of data (Table 3.3) on continuing and attrited families indicated six statistically significant group-by-status interactions out of the 63 tests which were completed ($p < .10$). Three of these were at the 30-month reassessment and three at the 42-month reassessment. No statistically significant group-by-status interactions were found at the 66-month, 78-month, or 90-month reassessments of cohort 1. Five of the six statistically significant interactions revealed dropout patterns that would favor the expanded intervention group. This type of bias is of greatest concern if the reassessment findings indicate differences in favor of the expanded intervention group since it would then be difficult to determine whether the differences were attributable to the intervention differences or to differential dropout. The fact that such differences have not appeared in the reassessment makes

Table 3.2

Reasons for Subject Attrition by Reassessment

Reason	Number of Subjects Lost*						
	8-Month Reassessment	18-Month Reassessment	30-Month Reassessment	42-Month Reassessment	66-Month Reassessment	78-Month Reassessment	90-Month Reassessment
Parental Refusal	3	4	7	8	3	5	5
Insufficient treatment duration							5
Discharged from EI services	1	1	1	1	0	0	0
Not Located	2	6	6	4	5	4	4
Missed Appointments**	3	2	4	4	1	1	0
Deceased	1	2	2	2	2	2	2
In & Out of Foster Care	1	2	2	2	0	0	0
Total	11	17	22	21	11	12	16

* N at pretest was 78, with 58 in cohort 1 and 20 in Cohort 2. Cohort 2 has been reassessed 3 times, and cohort 1 7 times.

** Children in this category missed at least 3 appointments for assessment.

attrition less of a threat. Furthermore, the fact that those variables that are most directly related to child development outcomes (BDI pretest scores) do not reveal group-by-status interaction makes us more confident that attrition, although it was substantial, did not have a biasing effect on the results. Finally, most of those variables on which there were group-by-status interactions are only weakly correlated with outcomes in this study, which also reduces the threat of attrition as a confounding factor in interpreting the results. Those that were correlated were accounted for by using them as covariates.

Demographic characteristics. Pretest demographic data for subjects participating in each reassessment to date are presented in Table 3.4. Participating families were predominantly Caucasian and lived in predominantly rural areas. Family incomes ranged from less than $5,000 to approximately $39,999, with 28% falling into the low SES category (below $10,000). The average number of years of education for parents was between 11 and 12 years for both groups. Of the 116 tests conducted comparing the two intervention groups, 17 were statistically significant ($p < .10$). For those differences most clearly related to intervention effectiveness (e.g. mother's education, father's education, income, percent of children in daycare, percent of mothers who work outside the home, and the number of hours mothers work outside the home), all indicated higher means in the expanded intervention group. However, the correlation between these variables and both child and family outcomes were quite low. Nevertheless, these findings suggest a slight pretest difference between groups at pretest in favor of the expanded intervention group. Analysis of covariance procedures were used to adjust for these differences (Taylor & Innocenti, 1993). No statistically significant differences on demographic variables were found for those children included in the 90-month reassessment.

Table 3.3

Attrition Data for the Arkansas Intensity Study

		Standard			Expanded			ANOVA					
								Group		Study Status		Group by Status	
Variable		$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	F	p	F	p	F	p
8-MONTH REASSESSMENT													
CA at pretest	IN	27.5	(14.2)	29	29.1	(12.9)	38	.07	.79	.98	.32	.01	.93
	OUT	23.4	(15.1)	7	24.3	(4.9)	4						
BDI DQ	IN	45.1	(25.6)	29	54.8	(25.5)	38	1.29	.26	.42	.52	.00	.99
	OUT	50.6	(28.3)	7	60.4	(14.0)	4						
Total PSI	IN	248.3	(55.1)	28	255.6	(49.5)	35	.02	.90	.00	.99	.07	.79
	OUT	236.4	(45.8)	7	224.8	(43.4)	4						
FRS	IN	115.8	(25.5)	29	114.2	(20.5)	37	.25	.62	.00	.99	.07	.79
	OUT	117.9	(25.1)	7	112.0	(17.6)	4						
FSS	IN	29.4	(11.6)	29	29.3	(12.4)	38	.06	.80	.01	.91	.08	.78
	OUT	27.9	(7.2)	7	30.0	(14.7)	4						
Mother Education	IN	11.6	(2.1)	28	12.2	(2.2)	38	.55	.46	.04	.84	2.09	.15
	OUT	12.9	(2.6)	7	11.3	(1.0)	4						
Father Education	IN	11.7	(1.5)	27	12.1	(2.4)	37	.31	.58	.01	.94	1.15	.29
	OUT	12.5	(2.7)	6	11.3	3.8	4						
Income	IN	$15,339	($9,470)	28	$17,868	($10,842)	38	.00	.95	.07	.80	.64	.30
	OUT	$19,000	($10,731)	7	$16,000	($7,506)	4						
Number of Home Visits	IN	29.14	(16.78)	29	68.53	(32.28)	38	12.58	.00	7.71	.01	1.09	.30
	OUT	14.29	(8.40)	7	35.75	(19.02)	4						
Percent Home Visits Attended	IN	84.25	(15.04)	29	82.29	(11.18)	38	1.48	.23	.00	.95	.57	.45
	OUT	87.21	(11.60)	7	78.78	(7.13)	4						
18-MONTH REASSESSMENT													
CA at Pretest	IN	27.5	(15.2)	26	27.8	(11.3)	35	1.35	.25	.09	.76	1.21	.28
	OUT	24.6	(14.8)	10	33.0	(17.4)	7						
BDI DQ	IN	46.1	(25.4)	25	53.4	(24.8)	35	3.54	.06	.54	.47	.82	.37
	OUT	45.3	(28.4)	10	64.9	(22.6)	7						
Total PSI	IN	243.7	(53.1)	25	254.6	(45.1)	32	.00	.97	.02	.89	.47	.49
	OUT	251.4	(55.1)	10	242.4	(68.9)	7						
FRS	IN	115.5	(25.8)	26	113.6	(18.7)	35	.13	.72	.10	.76	.01	.94
	OUT	118.0	(24.1)	10	115.2	(28.9)	6						
FSS	IN	30.8	(11.0)	26	30.6	(13.1)	35	.09	.77	4.59	.04	.05	.82
	OUT	24.7	(9.5)	10	23.0	(5.9)	7						
Mother Education	IN	11.8	(2.1)	26	11.9	(1.8)	35	.67	.47	1.99	.16	.46	.50
	OUT	12.2	(2.6)	9	13.1	(3.3)	7						
Father Education	IN	11.9	(1.4)	26	12.2	(2.3)	34	.04	.85	.52	.47	.46	.50
	OUT	11.9	(2.7)	7	11.3	(3.6)	7						
Income	IN	$15,653	($9,756)	26	$17,057	($9,750)	35	.74	.39	.88	.35	.14	.71
	OUT	$17,278	($9,941)	9	$20,857	($14,232)	7						
Number of Home Visits	IN	32.39	(15.40)	26	70.49	(32.63)	35	24.84	.00	14.94	.00	.38	.54
	OUT	10.30	(4.08)	10	40.00	(17.81)	7						
Percent Home Visits Attended	IN	83.79	(15.29)	26	81.96	(11.45)	35	1.10	.30	.28	.60	.28	.60
	OUT	87.53	(11.74)	10	81.96	(7.79)	7						

(continued)

* Statistical analyses for PSI and FILE were based on raw scores where low raw scores and positive ESs are most desirable. A low score indicates low stress or a low number of stress-associated life events.

* Analyses for the FSS and FRS are based on raw scores indicating the amount of support or resources indicated by the family as being available. Higher scores are considered better.

Table 3.3 (continued)

Attrition Data for the Arkansas Intensity Study

								ANOVA					
		Standard			Expanded			Group		Study Status		Group by Status	
Variable		$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	F	p	F	p	F	p
30-MONTH REASSESSMENT													
CA at pretest	IN	29.3	(15.3)	22	27.9	(12.5)	34	1.31	.26	.13	.72	2.47	.12
	OUT	22.6	(11.7)	14	32.0	(12.4)	8						
BDI DQ	IN	46.3	(26.3)	22	54.8	(26.2)	34	2.30	.13	.04	.84	.06	.81
	OUT	46.0	(26.0)	14	57.7	(17.2)	8						
Total PSI	IN	247.4	(50.8)	21	248.9	(47.6)	31	.78	.38	.25	.62	.60	.44
	OUT	243.6	(57.9)	14	266.9	(56.7	8						
FRS	IN	111.5	(26.7)	22	114.5	(20.2)	34	.69	.41	.46	.50	1.76	.19
	OUT	123.6	(21.0)	14	110.6	(20.5)	7						
FSS	IN	30.1	(11.5)	22	29.8	(12.9)	34	.00	.95	.62	.43	.00	.97
	OUT	27.6	(9.9)	14	27.5	(11.1)	8						
Mother Education	IN	11.3	(1.6)	22	12.1	(2.2)	34	.06	.81	1.00	.32	2.91	.09
	OUT	12.8	(2.8)	13	11.8	(1.9)	8						
Father Education	IN	11.5	(1.1)	22	12.3	(2.4)	33	.57	.45	.00	.98	4.91	.03
	OUT	12.7	(2.4)	11	11.0	(2.9)	8						
Income	IN	$13,227	($8,071)	22	$17,926	($10,985)	34	.01	.92	1.50	.22	2.89	.09
	OUT	$20,885	($10,570)	13	$16,668	($8,774)	8						
Number of Home Visits	IN	29.68	(16.86)	22	70.74	(33.12)	34	22.81	.00	7.80	.01	2.11	.15
	OUT	20.86	(15.11)	14	42.75	(17.95)	8						
Percent Home Visits Attended	IN	83.86	(15.78)	22	83.51	(8.19	34	3.04	.09	.75	.39	2.68	.11
	OUT	86.36	(12.11)	14	75.36	(17.66)	8						
42-MONTH REASSESSMENT													
CA at Pretest	IN	28.3	(15.4)	24	26.2	(11.0)	33	3.76	.08	1.00	.32	6.01	.02
	OUT	23.5	(11.7)	12	37.7	(15.4)	9						
BDI DQ	IN	48.2	(24.0)	24	55.9	(29.8)	33	2.63	.11	.11	.74	.35	.56
	OUT	42.1	(29.8)	12	56.6	(10.7)	9						
Total PSI	IN	253.4	(57.8)	23	249.8	(46.6)	31	1.19	.28	.04	.84	2.00	.16
	OUT	231.4	(40.4)	12	265.5	(60.5)	8						
FRS	IN	113.9	(25.9)	24	114.9	(20.8)	33	.74	.39	.02	.90	1.06	.31
	OUT	120.8	(23.5)	12	109.5	(17.3)	8						
FSS	IN	29.5	(12.4)	24	29.8	(12.6)	33	.00	.95	.30	.56	.02	.89
	OUT	28.5	(8.3)	12	27.7	(12.4)	9						
Mother Education	IN	11.3	(1.6)	24	12.5	(2.0)	33	1.59	.21	.01	.92	11.8	.00
	OUT	13.2	(2.8)	11	10.6	(2.3)	9						
Father Education	IN	11.5	(1.1)	23	12.3	(2.6)	32	.66	.42	.00	.99	5.39	.02
	OUT	12.8	(2.5)	12	11.0	(2.4)	9						
Income	IN	$15,312	($9,145)	24	$18,242	($10,783)	33	.03	.87	.00	.98	.87	.35
	OUT	$17,729	($11,046)	11	$15,609	($9,772)	9						
Number of Home Visits	IN	30.8	(17.5)	24	70.6	(31.6)	33	27.80	.00	8.40	.01	.66	.42
	OUT	17.2	(9.9)	12	46.3	(30.6)	9						

(continued)

- Statistical analyses for PSI and FILE were based on raw scores where low raw scores and positive ESs are most desirable. A low score indicates low stress or a low number of stress-associated life events.
- Analyses for the FSS and FRS are based on raw scores indicating the amount of support or resources indicated by the family as being available. Higher scores are considered better.

Table 3.3 (continued)

Attrition Data for the Arkansas Intensity Study

								ANOVA					
		Standard			Expanded			Group		Study Status		Group by Status	
Variable		$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	F	p	F	p	F	p
66-MONTH REASSESSMENT*													
CA at pretest	IN	27.4	(15.0)	18	27.0	(12.5)	29	.10	.75	.31	.58	.15	.70
	OUT	22.0	(15.4)	9	26.0	(4.2)	2						
BDI DQ	IN	44.9	(26.3)	18	56.0	(25.7)	29	1.21	.28	.06	.80	.01	.94
	OUT	46.7	(27.9)	9	59.7	(22.9)	2						
Total PSI	IN	264.2	(40.1)	18	244.9	(44.6)	29	1.49	.23	6.16	.02	.06	.80
	OUT	219.8	(69.6)	9	190.5	(9.2)	2						
FRS	IN	111.4	(27.7)	18	114.8	(19.6)	29	.01	.93	2.33	.13	.07	.79
	OUT	128.1	(18.1)	9	126.5	(9.2)	2						
FSS	IN	30.4	(12.9)	18	31.0	(12.9)	29	.19	.66	.00	.96	.11	.74
	OUT	28.4	(9.6)	9	32.5	(17.7)	2						
Mother Education	IN	10.8	(1.6)	18	12.2	(2.2)	29	.03	.87	.48	.49	2.22	.14
	OUT	12.6	(2.1)	8	11.5	(7)	2						
Father Education	IN	11.3	(1.1)	18	12.0	(2.5)	28	1.16	.29	.65	.42	.11	.74
	OUT	11.7	(1.7)	7	13.0	(4.20	2						
Income**	IN	27.8		18	41.4		29	.39	.54	.19	.66	.00	.98
	OUT	37.5		8	50.0		2						
78-MONTH REASSESSMENT*													
CA at pretest	IN	25.8	(14.7)	17	27.0	(12.5)	29	.03	.86	.02	.89	.00	.97
	OUT	25.2	(16.3)	10	26.0	(4.2)	2						
BDI DQ	IN	43.8	(26.7)	17	56.0	(25.7)	2	1.17	.28	.14	.71	.00	.96
	OUT	48.4	(26.8)	10	59.0	(22.9)	2						
Total PSI	IN	262.6	(46.2)	17	244.9	(44.6)	29	1.81	.18	5.03	.03	.22	.64
	OUT	226.9	(63.1)	10	190.5	(9.2)	2						
FRS	IN	113.3	(28.1)	17	114.8	(19.6)	29	.06	.80	1.33	.26	.01	.93
	OUT	123.3	(21.3)	10	126.5	(9.2)	2						
FSS	IN	31.9	(12.6)	17	31.0	(12.9)	29	.27	.60	.16	.69	.48	.49
	OUT	26.2	(9.7)	10	32.5	(17.7)	2						
Mother Education	IN	10.9	(1.7)	17	12.2	(2.2)	29	.13	.72	.08	.77	1.15	.29
	OUT	12.1	(2.3)	10	11.5	(7)	2						
Father Education	IN	11.5	(1.1)	17	12.0	(2.5)	28	1.53	.22	.20	.66	.48	.49
	OUT	11.3	(1.8)	10	13.0	(4.2)	2						
Income**	IN	35.3		17	41.4		29	.67	.42	.01	.72	.27	.60
	OUT	37.5		8	50.0		2						
90-MONTH REASSESSMENT													
CA at pretest	IN	26.2	(15.6)	17	27.2	(12.6)	24	.24	.63	.21	.65	.07	.80
	OUT	23.2	(15.0)	9	26.3	(11.4)	7						
BDI DQ	IN	49.2	(28.6)	17	53.7	(27.5)	24	3.01	.09	.15	.70	1.30	.26
	OUT	43.5	(23.9)	9	65.2	(12.9)	7						
Total PSI	IN	262.1	(45.2)	17	242.8	(44.7)	24	.05	.83	2.3	.14	1.2	.28
	OUT	223.7	(67.3)	9	236.7	(50.5)	7						
FRS	IN	109.9	(27.6)	17	113.0	(20.3)	23	.00	.96	5.0	.03	.27	.60
	OUT	127.9	(18.3)	9	124.1	(12.3)	7						
FSS	IN	28.4	(11.4)	17	32.0	(12.3)	24	.08	.78	.12	.73	.49	.49
	OUT	29.7	(10.7)	9	28.1	(15.2)	24						
Mother Education	IN	10.8	(1.6)	17	12.3	(2.3)	24	.38	.54	.67	.42	2.84	.10
	OUT	12.4	(2.3)	8	11.7	(1.4)	7						
Father Education	IN	11.2	(1.4)	17	12.2	(2.6)	23	.27	.61	.05	.82	.90	.35
	OUT	11.7	(1.7)	7	11.4	(2.5)	7						
Income**	IN	45.3		17	48.8		24	.64	.43	.09	.77	.14	.71
	OUT	42.5		8	50.0		7						

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* Attrition data reported for the 66-month, 78-month, and 90-month reassessments include only subjects in Cohort 1

** % with > $15,000 total household income

Table 3.4

Pretest Demographic Data for Subjects in the Arkansas Intensity Study

	8-Month Reassessment								18-Month Reassessment							
	Standard			Expanded					Standard			Expanded				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
Child's age (in months)	27.5	(14.2)	29	29.1	(12.9)	38	.64	-.07	27.5	(14.2)	26	27.8	(11.3)	35	.95	-.13
Mother's age	32.5	(7.0)	27	32.4	(7.4)	38	.95	-.01	31.9	(7.0)	25	31.5	(7.0)	34	.81	-.06
Father's age	34.3	(7.6)	27	35.0	(8.4)	37	.74	.09	33.7	(7.9)	26	34.0	(8.0)	33	.87	.04
Mother's education	11.6	(2.1)	28	12.2	(2.2)	38	.34	.29	11.8	(2.1)	26	11.9	(1.8)	35	.87	.05
Father's education	11.7	(1.5)	27	12.1	(2.4)	37	.42	.27	11.9	(1.4)	26	12.2	(2.3)	34	.50	.21
Percent with both parents living at home	79.3		29	84.2		38	.62	.13	84.6		26	85.7		35	.91	.04
Hours per week mother employed	8.5	(16.0)	28	20.1	(21.4)	38	.01	.73	10.7	(17.3)	26	18.9	(18.8)	35	.08	.47
Hours per week father employed	33.6	(21.5)	27	39.5	(16.6)	37	.24	.27	36.5	(19.5)	26	39.3	(18.2)	34	.57	.14
Percent mothers who work outside of home	28.6		28	55.3		38	.02	-.51	30.8		26	57.1		35	.04	-.50
Percent fathers in technical/managerial positions	7.4		27	16.2		37	.28	.21	7.7		26	11.8		34	.60	.09
Total Household Income	$15,339	($9,470)	28	$17,868	($10,642)	38	.32	.27	$15,653	($9,756)	26	$17,057	($9,749)	35	.58	.14
Percent on public assistance	53.6		26	52.6		38	.94	.02	50.0		26	48.6		35	.91	.03
Percent Mother as primary caregiver	62.8		29	81.6		38	.08	.42	84.6		26	80.0		35	.65	-.09
Percent in daycare > 5 hours per day	20.7		29	40.5		37	.15	-.39	23.1		26	42.7		35	.10	-.38
Number of siblings	1.5	(1.6)	28	1.2	(1.2)	38	.36	-.19	1.4	(1.3)	26	1.1	(1.1)	35	.40	-.23
Percent Male	62.1		29	63.2		38	.92	.02	61.5		26	57.1		35	.75	.08
Percent Caucasian	93.1		29	94.7		38	.74	.08	96.2		26	94.3		35	.88	.04

$$ES = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

Note: Effect sizes from percentages were computed from a _t_ statistic after an additional subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

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Table 3.4 (continued)

Pretest Demographic Data for Subjects in the Arkansas Intensity Study

	30-Month Reassessment								42-Month Reassessment							
	Standard			Expanded					Standard			Expanded				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES
Child's age (in months)	29.3	(15.3)	22	27.9	(12.5)	34	.71	-.24	28.3	(15.4)	24	26.2	(11.0)	33	.56	-.14
Mother's age	32.7	(7.4)	21	31.8	(7.0)	34	.66	-.12	33.8	(7.0)	23	33.1	(6.9)	33	.72	-.10
Father's age	33.9	(7.9)	22	34.2	(8.1)	33	.87	.04	35.6	(7.3)	23	35.4	(8.1)	32	.93	-.03
Mother's education	11.3	(1.6)	22	12.1	(2.2)	34	.11	.50	11.3	(1.6)	24	12.5	(2.0)	33	.02	.75
Father's education	11.5	(1.1)	22	12.3	(2.4)	33	.08	.73	11.5	(1.1)	23	12.3	(2.4)	32	.08	.73
Percent with both parents living at home	86.4		22	85.3		34	.91	.00	83.3		24	84.9		33	.88	.05
Hours per week mother employed	9.9	(17.4)	22	18.3	(18.7)	34	.09	.48	9.9	(16.9)	24	17.2	(18.9)	33	.13	.43
Hours per week father employed	33.3	(22.2)	22	38.8	(17.4)	33	.34	.25	35.8	(20.7)	23	39.2	(17.8)	32	.53	.16
Percent mothers who work outside of home	27.3		22	55.9		34	.03	-.54	29.2		24	57.5		33	.09	.54
Percent fathers in technical/managerial positions	0.0		22	15.2		33	.13	.40	4.4		23	15.6		32	.16	.28
Total Household Income	$13,227	($8,070)	22	$17,926	($10,986)	34	.07	.58	$15,313	($9,145)	24	$18,242	($10,783)	33	.27	.32
Percent on public assistance	54.6		22	52.9		34	.91	.03	45.8		24	57.6		33	.39	.22
Mother as primary caregiver	86.4		22	82.4		34	.69	-.07	83.3		24	81.8		33	.88	-.02
Percent in daycare > 5 hours per day	22.7		22	38.2		34	.22	-.29	20.8		24	36.4		33	.20	.30
Number of siblings	1.7	(1.7)	22	1.1	(1.2)	34	.21	-.35	1.7		24	1.1		33	.18	
Percent Male	68.2		22	61.8		34	.67	.11	58.3		24	57.6		33	.96	-.01
Percent Caucasian	95.5		22	94.1		34	.99	.00	95.8		24	93.9		33	.75	-.03

(continued)

$$\text{ES} = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

Note: Effect sizes from percentages were computed from a t statistic after an additional subject was added to each group in the comparison; those meeting the criteria and those that did not. This was done to ensure variance in group composition.

Table 3.4 (continued)

Pretest Demographic Data for Subjects in the Arkansas Intensity Study

	66-Month Reassessment**							
	Standard			Expanded				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
Child's Age (in months)	27.4	(14.9)	18	27.0	(12.5)	29	.93	-.03
Mother's age	27.6	(6.0)	17	29.1	(7.9)	29	.50	.25
Father's age	29.5	(7.1)	18	31.3	(9.2)	28	.44	.25
Father's education	11.3	(1.1)	18	12.0	(2.5)	28	.22	.64
Percent with both parents living at home	83.3		18	89.3		28	.59	.18
Hours per week mother employed	7.8	(16.0)	18	17.8	(19.4)	29	.06	.63
Hours per week father employed	33.5	(22.6)	18	39.0	(19.0)	28	.40	.24
Percent mothers who work outside of home	22.2		18	51.7		29	.04	.55
Percent fathers in technical/managerial positions	0.0		18	14.2		28	.22	.36
Total Household income*	27.8		18	41.4		29	.35	.24
Percent on public assistance	61.1		18	51.7		29	.54	-.17
Percent of Mother as primary caregiver	83.3		18	75.9		29	.54	-.13
Percent in daycare > 5 hours per day	0.0		18	34.5		29	.01	.75
Number of siblings	1.8	(1.6)	18	1.2	(1.1)	29	.14	-.37
Percent Male	66.7		18	58.6		29	.59	-.14
Percent Caucasian	94.4		18	93.1		29	.86	.01

$$\hat{ES} = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

* % with > $15,000 total household income
**Data reported here include only subjects in Cohort 1

Table 3.4 (continued)

Pretest Demographic Data for Subjects in the Arkansas Intensity Study

	78-Month Reassessment**							
	Standard			Expanded				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
Child's age (in months)	25.8	(14.7)	17	27.0	(12.5)	29	.79	.08
Mother's age	26.9	(5.6)	16	29.0	(7.9)	29	.31	.38
Father's age	29.3	(7.2)	17	31.3	(9.2)	28	.41	.28
Father's education	11.5	(1.1)	17	12.0	(2.5)	28	.37	.45
Percent with both parents living at home	82.4		17	89.3		28	.49	.21
Hours per week mother employed	9.4	(16.5)	17	17.8	(19.4)	29	.13	.51
Hours per week father employed	37.8	(19.6)	17	39.0	(19.0)	29	.85	.06
Percent mothers who work outside of home	29.4		17	51.7		29	.17	.40
Percent fathers in technical/managerial positions	5.9		17	14.3		28	.57	.17
Total Household income*	35.3	(49.3)	17	41.4	(50.1)	29	.69	.12
Percent on public assistance	52.9		17	51.7		29	.94	-.02
Percent of Mother as primary caregiver	82.4		17	51.7		29	.71	-.11
Percent in daycare > 5 hours per day	0.0		17	34.5		29	.01	.74
Number of siblings	1.5	(1.2)	17	1.2	(1.1)	29	.33	-.25
Percent Male	64.7		17	58.6		29	.73	-.10
Percent Caucasian	94.1		17	93.1		29	.92	.03

^

$$ES = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

* % with > $15,000 total household income

**Data reported here include only subjects in Cohort 1

Table 3.4 (continued)

Pretest Demographic Data for Subjects in the Arkansas Intensity Study

Variable	90-Month Reassessment**						p Value	ES
	Standard			Expanded				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n		
Child's age (in months)	26.2	(15.6)	17	27.1	(12.6)	24	.83	.06
Mother's age	28.7	(5.8)	16	28.4	(8.5)	24	.91	-.05
Father's age	30.7	(6.7)	17	31.2	(9.6)	23	.86	.07
Father's education	11.2	(1.1)	17	12.2	(2.6)	23	.16	.91
Percent with both parents living at home	88.3		17	87.0		23	.91	-.01
Hours per week mother employed	9.4	(16.5)	17	18.1	(19.4)	24	.14	.53
Hours per week father employed	35.5	(21.7)	17	40.9	(18.8)	23	.41	.25
Percent mothers who work outside of home	29.4		17	54.2		24	.12	.57
Percent fathers in technical/managerial positions	5.9		17	17.4		23	.29	.41
Total Household income*	35.3		17	41.7		24	.69	.14
Percent on public assistance	52.9		17	50.0		24	.86	-.07
Percent of Mother as primary caregiver	82.4		17	75.0		24	.59	-.19
Percent in daycare > 5 hours per day	0.0		17	29.2		24	.00	1.12
Number of siblings	2.0	(1.6)	17	1.3	(1.2)	24	.12	-.42
Percent Male	70.6		17	62.5		24	.60	-.19
Percent Caucasian	94.1		17	95.8		24	.81	.17

$$\hat{ES} = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

* % with > $15,000 total household income
**Data reported here include only subjects in Cohort 1

Intervention Programs

The expanded intervention was an extension of the standard service that was delivered prior to the initiation of the research. During the first year of the study, the intention was to provide services to the standard intensity group once every two weeks, and to the expanded intensity group twice per week, resulting in a 1:4 intensity comparison. In response to requests from the service providers to deliver services that more accurately reflected their preferred service model, the targeted level of services for the standard intensity group was increased to once per week during the second year of the study resulting in a 1:2 intensity difference. The ratio of the two interventions were comparable between each of the groups participating in the various reassessments (i.e., attrition did not cause the ratio to vary drastically) reflecting an average of a 2.36 standard to expanded intervention ratio across the reassessment years.

Standard intervention group. The standard intensity group received home visits from trained paraprofessionals. The preschool supervisor was responsible for training. As noted above, the intended frequency of home visits was once every other week during Year 1 and once per week during Year 2 of the study. The home teachers spent two weeks in individualized training, and were then closely supervised on their first home visits. Nine home teachers participated, two of whom had baccalaureate degrees, and all had extensive experience and background in early intervention. Three of the nine visitors had extensive experience with severely disabled populations. The others had backgrounds in Early Childhood Education, as indicated in Table 3.5.

Motor and speech/language therapists provided individual therapy on a weekly basis to children whose evaluation data indicated a therapy need. The children were brought to the centers for their therapy, lasting approximately one-half hour. The home-based intervention took place primarily in the subject's home, although a small number of children were visited in daycare centers or at baby sitters. Home teachers focused on working with the children directly. The parents were expected to observe and demonstrate to the home visitor what they had learned. Home visits lasted approximately one hour.

An Individual Education Plan (IEP) was developed for each child and was used to guide the home visitor in working with the child and parent(s) during the sessions. The content of home visits was taken from the IEP, which was based on recommendations made by the multidisciplinary assessment team (typically including a psychologist, speech/language pathologist, OT/PT, home visitor, and the child's parent). Goals and objectives for the child were agreed upon by the home visitor and the parent, which considered the parent's needs and the child's progress over time. A variety of assessment instruments and curricula were used to develop the objectives in the IEP. The IEPs were evaluated by the multidisciplinary team on a quarterly basis. All goals which had been achieved were recorded on a quarterly summary sheet and shared with the multidisciplinary team. (During the site visit described below, 10% of the IEPs were randomly sampled for evaluation and were found to be age appropriate, developmental, and functional in nature.)

Intervention programs focusing on development of functional skills were provided by the home visitors and were individualized based on the child's developmental level and family's functioning. Typical goals included self-help (particularly feeding), gross motor, and communication skills. Primary care takers developed skills in positioning, feeding, and in 15 cases, the use of medical technology such as oxygen, respirators, gavage feeding, and catheters. The home visitors were trained in these areas and helped parents meet the medical as well as developmental needs of their children. Children with less severe disabilities received programs focusing on their language, cognitive, self-help, and gross and fine motor needs.

Home visitors were assigned to children based on the children's level of functioning such that each visitor served approximately equal numbers of children in both groups. Table 3.5 indicates the number of children served by each visitor in each group. Each home visitor was observed at least two times annually by the EIRI staff coordinator, and consistently demonstrated knowledge, creativity, and sensitivity in dealing with young children with disabilities and their families. It is important to note that all but two of the teachers had nearly equal numbers of children in both groups, thus reducing the possibility of group differences resulting from differences between service providers.

Table 3.5
Teacher Qualification and Original Assignments

Teacher	Early Childhood Related Education	Experience	# of Children in Standard	# of Children in Expanded
1	14 years	1 year	5	4
2	12 years	6 years	4	6
3	12 years	1 year	0	2
4	B.A.	2 years	7	6
5	M.A.	3 years	5	7
6	12 years	10 years	6	6
7	12+ years	1 year	4	5
8	12+ years	1 year	5	5
9	B.A.	2 years	0	1
TOTAL			**36**	**42**

Home visits included the following activities: warm-up play period, discussion of current concerns and child's status, direct 1:1 programming designed to meet specific objectives, work with the parents, discussion of progress made towards objectives, and data recording. When ending the visit, the home visitor encouraged the parents to continue their efforts to assist their child and reminded them of the next visit and other scheduled therapies. Data sheets, program descriptions, detailed instructions, and materials were left for the parent to use. Program data and anecdotal notes were recorded by the home visitor after each appointment.

The curriculum was based on comprehensive assessments and a modification of the Learning Accomplishment Profile. The home visitor brought a variety of materials and toys for programs and the child's folder for recording data. She worked individually with the child, keeping data on 4 to 6 goal areas. Emphasis was placed on involving parents in the intervention activities. For example, the home visitor demonstrated how to position a child for feeding and, as the parent participated, provided modeling, shaping, prompting, and positive reinforcement to the parent. Once the home visitor had instructed the parent on how to carry out the activity, a schedule was set up for the parent to follow. The amount of time a parent was encouraged to spend with the child depended on the child's needs and the parent's willingness and ability.

Home visitors created data recording sheets for parents that included the following: (1) a specification of the activities to be conducted; (2) spaces to record data and duration of activity; and (3) spaces to record correct responses and errors, as well as progress made towards the objective. For example, in a feeding program, the key data recorded would be that the child consumed two ounces orally. In some cases, however, the only record made by parents was whether or not the activity took place or if the activity was successful.

Home visitors kept detailed data on the number of trials, correct and error rates, and a specified description of what progress took place toward each objective addressed. Anecdotal records described the session, the parent's and child's responses, and the home visitor's plans for the next session.

Expanded intensity group. The expanded intervention group received essentially the same type of service delivery (mean rate of attendance was 84%) as the standard intervention group, but with at least double the frequency of home visits.

Treatment Verification

__Intervention implementation__. A number of procedures were used to verify that the two interventions were being implemented as intended. The EIRI coordinator communicated with the on-site coordinator, on at least a weekly basis, who assisted in areas of program development and child-find efforts, and made periodic site visits. The site was visited three times during the 1987-1988 year by the EIRI site coordinator. Other program verification activities included the following:

1. __Collection of attendance data__. The child's participation in the program for both groups was recorded according to the length of the session and the staff involved. Non-attendance at regularly scheduled sessions was also recorded according to the reason for non-attendance. Analysis of attendance data indicated that the rates of attendance at home visits were nearly equal across the two groups during the two intervention years (1986-88).

2. __Data describing the level of parent involvement__. Home teachers rated parents in three areas: attendance (in IEP meetings, therapy, home visits), knowledge regarding their child and their rights, and support activities (follow through, communication with staff, form completion, etc.). Parents were rated on each area with a 3-point scale, 1 = low, 2 = average, 3 = high. Table 3.6 contains the results of the teachers' ratings of parent involvement for the two years of the intervention implementation. A statistically significant difference was found between the standard and expanded intervention groups, indicating that the teachers rated parents in the expanded group as more supportive of the child's program activities than those in the standard group.

3. __Teacher evaluations__. The preschool supervisor evaluated teachers using two scales developed by EIRI staff. One was a 3-point scale (2 = criteria fully met; 1 = partially met; 0 = not met) that addressed five areas: teacher assessment skills, IEP development skills, IEP implementation skills, presentation of instruction, and instructional environment. The second assessed six teacher traits (teaching skills, problem solving, work habits, relationships, communication skills, and attitude) on a 5-point scale (5 = outstanding, 4 = very good, 3 = good, 2 = needs improvement, and 1 = inadequate). Thus, the minimum possible score was 6 and the maximum possible score was 30. Actual teacher rating totals ranged from 21 to 30. Although there were some differences among teachers, the fact that teachers had children in each group means that these differences did not bias the results of the study.

Table 3.6

Teacher Ratings of Parent Involvement* in the Home Visit Program

Variable	Standard $\bar{x}$	Standard (SD)	Standard n	Expanded $\bar{x}$	Expanded (SD)	Expanded n	p Value	ES
8-MONTH REASSESSMENT								
Attendance at visits and other activities	2.1	(.8)	29	2.3	(.7)	38	.24	.28
Knowledge/Understanding of child's program	1.9	(.9)	29	2.2	(.8)	38	.16	.33
Support of the child's program/activities	1.7	(.8)	29	2.1	(.8)	38	.05	.51
18-MONTH REASSESSMENT								
Attendance at visits and other activities	2.1	(.8)	26	2.2	(.7)	33	.62	.12
Knowledge/Understanding of child's program	2.0	(.8)	26	2.1	(.8)	33	.54	.16
Support of the Child's Program/Activities	1.8	(.8)	26	2.0	(.8)	33	.22	.34

$$ES = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

*1 = Some involvement; 2 = Moderate Involvement; 3 = High Involvement

4. **Parent Satisfaction Data**. Parents completed a seven-item Satisfaction with Services Form to assess the degree to which parents in each group were satisfied with the services they received. Table 3.7 includes the parent satisfaction data collected during the intervention years. No statistically significant differences were found between groups in any of the areas addressed, but three effect sizes greater than .30 were found. The expanded group tended to feel better in all areas except one, but both groups reported satisfaction in all areas. Additionally, there is a statistically significant correlation between parent satisfaction data and teacher ratings of parent involvement. This relationship is particularly strong between parent ratings of satisfaction with the opportunities they were given to participate in the development and implementation of their child's program. This suggests that the more parents were involved in their child's program, the more satisfied they were. The fact that satisfaction was measured on a 4-point scale and all means were above 3 suggests that parents in both groups were very satisfied.

5. **Site Review**. Formal site reviews were conducted at the end of each treatment year as a part of a continuous effort to verify that treatment was taking place as planned. The EIRI Site Coordinator met with both Richardson and Sunshine Coordinators as well as with parents, ancillary staff, and all home teachers. In addition, the EIRI Site Coordinator attended a sample of home visits to observe each teacher at work. Results of the site reviews indicated that the program was well administered and that each intervention was implemented as intended. The program files were in good order, containing up-to-date IEPs, quarterly reports of progress, assessment information, and description of services received. Randomly selected IEPs were reviewed, and all were found to contain the following: (1) a statement of current level of performance (both norm and criterion referenced); (2) annual goals and short-term objectives that were functional, appropriate, and individualized; (3) evaluation of criteria for determining when the objectives were met; and (4) timelines for monitoring.

Table 3.7
Parent Ratings of the Quality of the Home Visit Program*

Study Year	Standard $\bar{x}$	Standard (SD)	Standard n	Expanded $\bar{x}$	Expanded (SD)	Expanded n	p Value	ES
8-MONTH REASSESSMENT								
Program Staff	3.82	(.39)	28	3.88	(.33)	34	.51	.15
Communication with staff	3.71	(.46)	28	3.59	(.61)	34	.36	-.26
Program Goals	3.54	(.58)	28	3.68	(.54)	34	.33	.24
Participation	3.54	(.69)	28	3.59	(.61)	34	.76	.07
Range of Services	3.36	(.62)	28	3.47	(.66)	34	.49	.18
Child Progress	3.10	(1.17)	28	3.44	(.89)	34	.22	.29
Overall	3.18	(1.20)	28	3.59	(.9)	34	.10	.34
18-MONTH REASSESSMENT								
Program Staff	3.80	(.41)	25	3.86	(.35)	29	.56	.15
Communication with staff	3.76	(.44)	25	3.52	(.63)	29	.10	-.55
Program Goals	3.56	(.58)	25	3.62	(.56)	29	.70	.01
Participation	3.56	(.71)	25	3.55	(.63)	29	.96	.01
Range of services	3.40	(.65)	25	3.41	(.68)	29	.94	.02
Child Progress	3.08	(1.22)	25	3.34	(.94)	29	.38	.21
Overall	3.16	(1.18)	25	3.51	(.74)	29	.20	.30

^

$$ES = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

* Ratings ranged from 1 = Poor to 4 = Excellent.

Cost of alternative interventions. The cost of delivering the intervention programs described above was determined using the ingredients approach (Levin, 1983). The ingredients approach is a systematic, well-tested procedure for identifying all of the social costs for implementing alternative programs, including costs that are often omitted from cost analysis such as contributed (in-kind) and shared resources. In this approach, an exhaustive list of resources used by each alternative is developed, and the ingredients are costed according to observed market values (e.g., salaries) or opportunity cost (e.g., parent time). An opportunity cost is the value of a resource in its next best alternative use. For example, parents participating in intervention activities could have been engaged in other productive activities; these foregone activities represent a cost to parents. Since we have no information about any one individual's opportunity costs, we estimated the value of an individual's time based on national data. The amount of parent or non-parent volunteer time required for the study was assigned the pecuniary value of $9 per hour based on the "median usual weekly earning for full-time work" plus benefits (U.S. Department of Labor, Bureau of Labor Statistics, 1989).

All costs are from the 1987-88 fiscal year (July to June) and are expressed in 1990 dollars. In cases where program costs were compared over several years, costs were adjusted for inflation using the Fixed Weighted Price Index for state and local government purchases (Bureau of Economic Analysis, 1991).

Costs are based on actual expenditures for direct service and administrative personnel, occupancy, equipment, travel, materials and supplies, miscellaneous and contributed resources. Total costs in each resource category for both programs were first added together and then prorated according to program intensity: 60% of resources were consumed by the expanded program and 40% by the low-intensity program. Cost per child was determined by dividing total resource cost in each category by the number of children receiving services in each group. Table 3.8 presents the cost per child in each of these resource categories.

Table 3.8
Cost Per Child for Sunshine School/Richardson Center

Resources	Expanded Intensity	Standard Intensity
Agency Personnel:		
Direct Service	$ 4,336	$2,169
Administrative	1,658	828
Facilities	561	281
Equipment	118	59
Materials/Supplies	244	121
Staff Transportation	395	198
Miscellaneous	807	403
Subtotal	**$ 8,118**	**$4,059**
Contributed Resources:		
Parent time	927	610
Parent Travel	332	166
Volunteer	32	16
Subtotal	**$ 1,291**	**$ 792**
TOTAL	**$ 9,409**	**$4,851**

Totals may not add up due to rounding errors

Direct service and administrative costs included salaries plus benefits for each staff member according to the percentage of FTE allocated to the program. Occupancy charges were based upon the replacement value of the facilities in which the programs were housed, annualized to account for interest and depreciation, and included all utilities, insurance, and maintenance costs. Equipment costs were based on the market replacement value of office furniture and equipment used by the program and also included equipment repair. Equipment cost, such as facilities, was annualized to account for interest and depreciation. Staff transportation costs for home visits and other job-related travel were reimbursed by Sunshine Preschool and Richardson Center at the rate of $.23 per mile and $.22 per mile, respectively. The cost for materials, supplies, and miscellaneous included the annual expense for all consumable items and miscellaneous expenses incurred by each program.

Contributed resources included the value of volunteer and parent time. Parents were interviewed via telephone to determine the time and out-of-pocket expenses incurred getting their children to the center for therapy sessions. All parent and volunteer time in the program was assigned the opportunity cost of $9 per hour, and mileage was estimated at $.21 per mile.

Data Collection

Data concerning child and family functioning were collected at enrollment, eight months later, and annually thereafter. Testing procedures are presented below.

Recruitment, training, and monitoring of diagnosticians. During the pretest and the 8-, 18-, 30- and 42-month reassessment years, three diagnosticians and a local assessment supervisor, who had been trained and certified by EIRI standards, were responsible for completing the testing. None were employed by either service provider, and testing assignments were made by the assessment supervisor to ensure that all diagnosticians were unaware of subjects' group placement. The diagnosticians possessed master's degrees in psychology, and the supervisor had a doctoral degree. The assessment supervisor was responsible for shadow scoring 10% of each diagnostician's test administrations, scheduling testing, and collecting, reviewing, and sending all protocols to the EIRI site coordinator. Interrater reliability for the shadow scored Battelle Developmental Inventories were calculated by dividing the number of agreements by the total number of items administered. Reliability coefficients averaged .95 (range .80 to 1.00).

For the 66-month, 78-month, and 90-month reassessments, it was necessary to locate three additional diagnosticians to work with two of the diagnosticians who had tested during the previous reassessment. All five had extensive experience working with children who have developmental disabilities. In addition, four of the five diagnosticians had Master's degrees in fields related to special education, while one had completed graduate courses toward a Master's degree. All diagnosticians were trained to administer the child and family measures and were certified according to established EIRI standards. During the course of the assessment, 10% of test administrations were shadow scored by a second diagnostician and the mean interrater reliability coefficient for the Woodcock-Johnson Tests of Achievement-Revised and the Scales of Independent Behavior (two of the main child functioning measures used for the 66-month reassessment) exceeded .98. One of the most experienced diagnosticians also served as the assessment coordinator and reviewed all completed protocols before forwarding them to EIRI.

Testing. Parents of each child participating in the study signed an informed consent form and provided demographic information. At the pretest, children were administered the Battelle Developmental Inventory, and parents completed the Parenting Stress Index (PSI), Family Support Scale (FSS), Family Resource Scale (FRS), Family Inventory of Life Events and Changes (FILE), and the Family Adaptability and Cohesion Evaluation Scales (FACES III). Parents were paid a $20 incentive at pretest, $30 at 8-month reassessment, and $50 at subsequent reassessments. The schedule for test administration is presented in Table 3.9 and includes descriptions of several additional measures which were included for the first time at the 66-month reassessment and then again during the 78-month and 90-

month reassessments. Due to the maturation of the subjects, several new child functioning measures (the Woodcock-Johnson Test of Achievement-Revised [WJ-R], the Scales of Independent Behavior [SIB], the Social Skills Rating Scale, and the Inferred Self-Concept Scale) were introduced at the 66-month reassessment to replace the Battelle Developmental Inventory (BDI), the Sequenced Inventory of Communication Development, and the Vineland Adaptive Behavior Scales--Survey Edition. It should be noted that while the SIB was completed on all subjects, four subjects in the standard group and six subjects in the expanded group could not obtain basal scores on the WJ-R at the 66-month reassessment. At the 78-month reassessment, the same 10 subjects could not obtain a basal score on the WJ-R. During the 90-month reassessment, 9 subjects continuing in the study were unable to obtain basal scores on the WJ-R.

Most of the standardized measures described in Table 3.9 were used as outcome measures of child or family functioning. It was believed that intervention services would impact stress by helping families be more effective in dealing with their children with disabilities. Services were also believed to impact family adaptability and cohesion by teaching strategies for rearing children with disabilities that would facilitate changes in the patterns of interaction between spouses/mates and other children in the home. It was found that more cohesive families (as measured by the FACES) and those with more resources (as measured by the FRS) tended to report lower levels of stress. Thus, the FACES was considered as an outcome variable. The FRS and the FSS were used as contextual variables because they elicited descriptions of the resources and support available to the families, variables which may have influenced the effectiveness of the two interventions examined in this study. The FILE was considered a contextual variable because the events it records have both theoretical and data driven relationships with stress

Table 3.9

Description of Child and Family Measures and Schedule of Administration

MEASURES	DESCRIPTION	Assessment	8-Month Reassess.	18-Month Reassess.	30-Month Reassess.	42-Month Reassess.	66-Month Reassess.	78-Month Reassess.	90-Month Reassess.
Family Adaptability and Cohesion Evaluation Scale--(FACES III) (Olson, Portner, & Lavee, 1985)	Provides a general picture of family functioning by assessing the family's level of adaptability and cohesion. Family cohesion assesses degree of separation or connection of family members to the family. Adaptability assesses the extent to which the family system is flexible and able to change in various situations.	x	x	x	x	x			
Additional Services (E.I.R.I)	Provides data on services the child and family have received during the past year outside the study (e.g., School, Early Intervention, Speech Therapy, Physical and Occupational Therapy, Tutoring).		x	x	x	x	x	x	x
Parent Self-Awareness Scale (PSAS) (Snyder, Weeldreyer, Dunst, & Cooper, 1985)	The PSAS is a 20-item questionnaire that measures the parent's perceived level of personal capabilities, decision-making capabilities, and informational capabilities.						x	x	
Social Readjustment Rating Scale (SRRS) (Holmes & Rahe, 1967)	The SRRS measures parental stress by assigning numerical values to various positive and negative life events occurring within the last year. A separate score of the occurrence of major negative events is also provided.						x	x	x
Teacher Rating of Parent's Participation in Education Program (E.I.R.I.)	Assesses parental support/participation and knowledge of the child's educational program.						x	x	x
Battelle Developmental Inventory (BDI) (Newborg et al., 1984)	A norm-referenced test of developmental functioning completed through child administration and parent interview. Assesses personal/social, adaptive, motor, communication, and cognitive skills, and provides a total score.		x	x	x	x	x		
Sequenced Inventory of Communication Development (SICD) (Hedrick, Prather, & Tobin, 1984)	A measure of communication skills for children from birth to 48 months of age. Includes receptive and expressive communication domains.			x	x	x			

(continued)

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Table 3.9 (continued)

Description of Child and Family Measures and Schedule of Administration

MEASURES	DESCRIPTION	Assessment	8-Month Reassess.	18-Month Reassess.	30-Month Reassess.	42-Month Reassess.	66-Month Reassess.	78-Month Reassess.	90-Month Reassess.
The Vineland Adaptive Behavior Scales--Survey Edition (Sparrow, Balla, & Cicchetti, 1984)	This version provides a general assessment of adaptive behavior, covering the domains of communication, daily living skills, socialization, and motor skills. It is administered to a parent or caregiver in a semistructured interview format. It is appropriate for use with persons ages birth to adult. Standard scores and age equivalents are obtainable. Norms for special populations (i.e., visually impaired) are also provided. Interrater reliabilities, internal consistencies, and concurrent validity data strongly support its use.		x	x	x	x			
Child Health (E.I.R.I.)	Assesses the parent's evaluation of the child's health during the past year, including general health, illnesses, hospitalization, etc.		x	x	x	x	x	x	x
Woodcock-Johnson Tests of Achievement--Revised (WJ-R) (Woodcock & Johnson, 1989)	A norm-referenced test of achievement. The test consists of six aspects of scholastic achievement: Letter-Word Identification, Applied Problems, Dictation, Science, Social Studies, and Humanities. Child is the respondent.						x	x	x
Scales of Independent Behavior (SIB)(Bruininks, Woodcock, Weatherman, & Hill, 1985)	The SIB is a norm-referenced test which assesses the functional independence and adaptive behavior of a child. The test is organized into four subdomains: Motor Skills, Social and Communication Skills, Personal Living Skills, and Community Living Skills. Parent is interviewed for information.						x	x	x
Social Skills Rating System--Parent Form (PSSRS) (Gresham & Elliot, 1990)	The PSSRS measures the parent's estimate of the child's social skills such as: Control, Assertion, Responsibility, and Self-Control. Problem behaviors that are also assessed are: Externalizing, Internalizing, and Hyperactivity.						x	x	x
Social Skills Rating System --Teacher Form (TSSRS) (Gresham & Elliot, 1990)	The TSSRS measures the teacher's estimate of the child's social skills such as: Control, Assertion, and Self-Control. Ratings of problem behaviors (Externalizing, Internalizing, and Hyperactivity) and academic competence are also assessed.						x	x	x
Inferred Self-Concept Scale (ISCS) (McDaniel, 1973)	Assesses the subject's self-esteem based on observed behavior. Consists of 30 statements about student behavior that the teacher rates on a 5-point scale to provide a total inferred self-concept score.							x	x

(continued)

Table 3.9 (continued)

Description of Child and Family Measures and Schedule of Administration

MEASURES	DESCRIPTION	Assessment	8-Month Reassess	18-Month Reassess	30-Month Reassess	42-Month Reassess	66-Month Reassess	78-Month Reassess	90-Month Reassess
Parenting Stress Index (PSI) (Abidin, 1983)	Assesses parent perceptions of stress on the parent-child system. The two main domains are child-related factors and parent factors.	x	x	x	x	x			
Parenting Stress Index (PSI) Short Form (Abidin, 1990)	Abbreviated version of the 1983 PSI with a total of 36 items.						x	x	x
Family Support Scale (FSS) (Dunst, Jenkins, & Trivette, 1984)	Assesses the availability of sources of support as well as the degree to which different sources of support provided perceived as helpful to families rearing young children.	x	x	x	x	x	x	x	x
Family Resource Scale (FRS) (Dunst & Leet, 1985)	Assesses the extent to which different types of resources are perceived as adequate in households with young children. Factors include: General Resources, Time Availability, Physical Resources, and External Support.	x	x	x	x	x	x	x	x
Family Inventory of Life events and Changes (FILE) (McCubbin, Patterson, & Wilson, 1983)	Assesses life events and changes experienced by a family unit during the past 12 months and prior to the past 12 months. The specific areas of potential strain covered by the scale include: Intra-Family, Marital, Pregnancy and Childbearing, Finance and Business, Work-Family Transitions, Illness and Family "Care," Losses, Transitions "In and Out," and Legal.	x	x	x	x	x			
Parent Feedback About Early Intervention Services									x

among families of children with disabilities. At the 66-month reassessment the Social Readjustment Rating Scale (SRRS) replaced the FILE due to criticisms from families regarding the intrusiveness of some of the items of the FILE. Used in the 78-month reassessment as well, the SRRS examined similar constructs including stress associated with significant life events.

Beginning with the 66-month reassessment, cohort 2 was no longer followed in this study. The decision was reached based on two factors. First, cohort 2 had experienced a 60% attrition rate, resulting in only 8 remaining subjects, two of whom were likely to be unable to obtain basal scores on the WJ-R due to their low level of functioning. Second, a shift in service provision during the second year of the study resulted in cohort 2 having received a different service intensity ratio than cohort 1 had received. Thus, rather than strengthening the study by increasing the number of subjects, as was originally intended, the continued inclusion of cohort 2 in longitudinal follow-up appeared to present a threat to the validity of the study. Longitudinal follow-up of cohort 1, however, allows for continued examination of intervention intensity differences with only minor threats to validity.

Results and Discussion

Comparability of Groups on Pretest Measures

Pretest data from child and family measures appear in Table 3.10. As can be seen, Table 3.10 summarizes pretest data in seven consecutive groups, each representing the pretest comparisons for subjects included in each reassessment. No statistically significant pretest differences were found in any BDI domain, although the expanded group performed at slightly higher DQ levels in all domains.

Table 3.10

Pretest Data for Children and Families in the Arkansas Intensity Study

	8-Month Reassessment										18-Month Reassessment									
	Standard				Expanded						Standard				Expanded					
Variable	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	P Value	ES^	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	P Value	ES^
Battelle Developmental* Inventory (BDI)																				
Personal/Social	45.1	(24.8)		29	53.3	(23.7)		38	.18	.33	46.2	(24.4)		26	51.5	(24.4)		35	.38	.22
Adaptive Behavior	33.5	(20.2)		29	40.1	(17.4)		38	.16	.33	34.8	(20.6)		26	38.3	(15.7)		35	.47	.17
Motor	45.2	(35.4)		29	54.6	(28.4)		38	.25	.27	44.9	(35.3)		26	50.9	(26.6)		35	.47	.17
Communication	22.4	(16.3)		29	26.7	(13.2)		38	.29	.26	23.1	(16.1)		26	25.1	(12.4)		35	.61	.12
Cognitive	19.2	(13.8)		29	22.2	(9.2)		38	.32	.22	19.2	(13.6)		26	21.5	(9.1)		35	.45	.17
TOTAL	165.2	(106.4)		29	196.4	(87.5)		38	.20	.29	168.2	(106.4)		26	187.4	(80.6)		35	.44	.18
Parent Stress Index•• (PSI)																				
Child Related	121.3	(27.8)	89	28	120.4	(23.8)	88	35	.89	.03	118.8	(28.2)	87	25	120.0	(22.2)	88	32	.86	-.04
Other Related	127.0	(32.3)	61	28	135.2	(30.5)	73	35	.31	-.25	124.9	(30.3)	58	25	134.6	(28.7)	73	32	.23	-.32
TOTAL	248.3	(55.1)	78	28	255.6	(49.5)	84	35	.59	-.13	243.7	(53.1)	75	25	254.8	(45.1)	83	32	.42	-.21
Family Adaptation and Cohesion Evaluation Scales (FACES)																				
Adaptation	23.3	(7.3)		29	21.8	(5.4)		36	.35	-.21	23.9	(7.4)		26	21.6	(5.5)		36	.95	-.31
Cohesion	39.7	(7.0)		29	39.1	(5.3)		36	.71	-.09	40.4	(7.1)		26	39.2	(5.5)		33	.19	.17
Family Resource Scale♦♦ (FRS)	115.8	(25.5)	46	29	114.0	(20.5)	41	37	.76	-.07	115.5	(25.6)	46	26	113.6	(16.7)	41	35	.75	-.07
Family Support Scale♦♦ (FSS)	29.4	(11.6)	54	29	29.3	(12.4)	54	36	.96	-.01	30.8	(10.9)	63	26	30.6	(13.1)	63	35	.94	-.02
Family Inventory of•• Life Events (FILE)	8.7	(4.9)	47	29	12.2	(8.4)	29	36	.04	-.71	8.7	(5.3)	47	25	11.8	(7.4)	29	33	.07	-.58

(continued)

* Statistical analysis for BDI scores were conducted using raw scores only.

^

$$ES = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

• Statistical analyses and Effect Size (ES) estimates for PSI and FILE were based on raw scores where low raw scores and positive ESs are most desirable. For ease of interpretation, the table also includes an approximate percentile based on the covariance adjusted score and the norming sample reported in the technical manuals (see Appendix A for details). A low percentile score indicates low stress or a low number of stress-associated life events.

♦ Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

* No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on 645 pretests on children with disabilities collected as part of the longitudinal studies.

Table 3.10 (continued)

Pretest Data for Children and Families in the Arkansas Intensity Study

	30-Month Reassessment										42-Month Reassessment									
	Standard				Expanded						Standard				Expanded					
Variable	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	P Value	ES	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	P Value	ES
Battelle Developmental' Inventory (BDI)																				
Personal/Social	47.6	(26.4)		22	52.2	(23.8)		34	.51	.17	46.1	(26.1)		24	49.8	(23.2)		33	.58	.14
Adaptive Behavior	35.7	(22.3)		22	39.0	(17.2)		34	.55	.15	35.6	(21.1)		24	37.2	(16.5)		33	.76	.08
Motor	50.0	(37.9)		22	51.6	(28.3)		34	.86	.04	50.8	(35.9)		24	48.8	(26.8)		33	.82	-.06
Communication	24.8	(17.7)		22	25.1	(12.7)		34	.96	.02	23.1	(17.3)		24	23.9	(12.5)		33	.84	.05
Cognitive	20.5	(15.0)		22	21.6	(9.1)		34	.77	.07	20.6	(14.3)		24	20.5	(8.8)		33	.99	-.01
TOTAL	178.6	(116.0)		22	189.4	(86.7)		34	.71	.09	176.1	(111.0)		24	180.2	(83.5)		33	.88	.04
Parent Stress Index'' (PSI)																				
Child Related	122.6	(27.7)	92	21	116.4	(22.8)	85	31	.40	.22	124.7	(29.3)	92	23	117.4	(23.7)	86	31	.33	.25
Other Related	124.8	(28.0)	58	21	132.5	(29.8)	71	31	.35	-.28	128.7	(32.8)	65	23	131.6	(28.5)	70	31	.73	-.09
TOTAL	247.4	(50.8)	77	21	248.9	(47.6)	79	31	.92	-.03	253.4	(57.8)	82	23	249.0	(46.6)	79	31	.77	.08
Family Adaptation and Cohesion Evaluation Scales (FACES)																				
Adaptation	22.5	(6.3)		22	21.7	(5.5)		32	.59	-.22	23.6	(7.9)		24	21.3	(5.4)		31	.23	-.29
Cohesion	38.7	(7.5)		22	39.2	(5.5)		32	.78	-.11	39.2	(7.5)		24	39.5	(5.6)		31	.88	.04
Family Resource Scale** (FRS)	111.5	(26.7)	39	22	114.5	(20.2)	43	34	.66	.11	113.9	(25.9)	41	24	114.9	(20.8)	43	33	.88	.04
Family Support Scale** (FSS)	30.1	(11.5)	57	22	29.8	(12.9)	57	34	.92	-.03	29.5	(12.0)	54	24	29.8	(12.6)	57	33	.93	.03
Family Inventory of'' Life Events (FILE)	9.0	(5.4)	47	21	11.3	(7.6)	34	32	.21	-.43	9.1	(5.2)		24	11.5	(7.3)		31	.11	-.46

(continued)

Statistical analysis for BDI scores were conducted using raw scores only.

$$ES = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

Statistical analyses and Effect Size (ES) estimates for PSI and FILE were based on raw scores where low raw scores and positive ESs are most desirable. For ease of interpretation, the table also includes an approximate percentile based on the covariance adjusted score and the norming sample reported in the technical manuals (see Appendix A for details). A low percentile score indicates low stress or a low number of stress-associated life events.

◆ Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

* No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on 645 pretests on children with disabilities collected as part of the longitudinal studies.

Table 3.10 (continued)

Pretest Data for Children and Families in the Arkansas Intensity Study

	66-Month Reassessment									
	Standard				Expanded					
Variable	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	p Value	ES
Battelle Developmental* Inventory (BDI)										
Personal/Social	42.1	(23.9)		18	52.3	(23.4		29	.16	.43
Adaptive Behavior	31.3	(19.8)		18	39.3	(17.1)		29	.17	.40
Motor	45.6	(37.9)		18	50.0	(25.9)		29	.67	.12
Communication	22.1	(16.3)		18	25.1	(12.8)		29	.50	.18
Cognitive	18.6	(13.8)		18	21.4	(8.6)		29	.44	.20
TOTAL	159.7	(198.5)		18	188.2	(83.4)		29	.35	.26
Parent Stress Index* (PSI)										
Child Related	131.7	(22.0)	95	18	115.7	(22.8)	85	29	.02	.73
Other Related	132.4	(24.6)	70	18	129.2	(27.7)	65	29	.68	.13
TOTAL	264.2	(40.1)	89	18	244.9	(44.6)	76	29	.13	.48
Family Adaptation and Cohesion Evaluation Scales (FACES)										
Adaptation	23.3	(8.9)		18	21.0	(5.6)		27	.35	-.26
Cohesion	35.5	(8.4)		18	39.9	(5.5)		27	.54	.52
Family Resource Scale** (FRS)	111.4	(27.7)	38	18	114.8	(19.6)	39	28	.66	.12
Family Support Scale** (FSS)	30.4	(12.9)	57	18	31.0	(12.9)	63	29	.89	.05
Family Inventory of* Life Events (FILE)	9.8	(5.1)		18	11.5	(7.7)		28	.39	-.33

* Statistical analysis for BDI scores were conducted using raw scores only.

$$\text{ES} = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

* Statistical analyses and Effect Size (ES) estimates for PSI and FILE were based on raw scores where low raw scores and positive ESs are most desirable. For ease of interpretation, the table also includes an approximate percentile based on the covariance adjusted score and the norming sample reported in the technical manuals. A low percentile score indicates low stress or a low number of stress-associated life events.

◆ Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

* No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on 645 pretests on children with disabilities collected as part of the longitudinal studies

Table 3.10 (continued)

Pretest Data for Children and Families in the Arkansas Intensity Study

	78-Month Reassessment									
	Standard				Expanded					
Variable	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	p Value	ES
Battelle Developmental' Inventory (BDI)										
Personal/Social	39.3	(23.0		17	52.3	(23.4)		29	.08	.57
Adaptive Behavior	30.5	(19.8)		17	39.3	(17.1)		29	.14	.44
Motor	40.7	(36.7)		17	50.0	(25.9)		29	.37	.25
Communication	20.0	(15.9)		17	25.1	(12.8)		29	.27	.32
Cognitive	16.8	(13.2)		17	21.4	(8.6)		29	.21	.35
TOTAL	147.3	(105.5)		17	188.2	(83.4)		29	.18	.39
Parent Stress Index' (PSI)										
Child Related	130.6	(24.7)	68	17	115.7	(22.8)	41	29	.05	-.60
Other Related	132.0	(27.5)	95	17	129.2	(27.7)	95	29	.75	-.10
TOTAL	262.9	(46.2)	88	17	244.9	(44.6)	75	29	.21	-.38
Family Adaptation and Cohesion Evaluation Scales (FACES)										
Adaptation	24.4	(8.7)		17	21.0	(5.6)		27	.17	-.39
Cohesion	39.4	(8.3)		17	39.9	(5.5)		27	.82	.06
Family Resource Scale" (FRS)	113.3	(28.1)	40	17	114.8	(19.6)	43	29	.85	.05
Family Support Scale" (FSS)	31.9	(12.6)	67	17	31.0	(12.9)	67	29	.82	.07
Family Inventory of' Life Events (FILE)	9.9	(5.3)		17	11.5	(7.7)		28	.44	.30

· Statistical analysis for BDI scores were conducted using raw scores only.

^

$$ES = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

· Statistical analyses and Effect Size (ES) estimates for PSI and FILE were based on raw scores where low raw scores and positive ESs are most desirable. For ease of interpretation, the table also includes an approximate percentile based on the covariance adjusted score and the norming sample reported in the technical manuals. A low percentile score indicates low stress or a low number of stress-associated life events.

◆ Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

• No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on 645 pretests on children with disabilities collected as part of the longitudinal studies

Table 3.10 (continued)

Pretest Data for Children and Families in the Arkansas Intensity Study

	90-Month Reassessment									
	Standard				Expanded					
Variable	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	p Value	ES
Battelle Developmental' Inventory (BDI)										
Personal/Social	44.2	(22.7)		17	52.2	(24.4)		24	.29	.35
Adaptive Behavior	33.2	(19.2)		17	38.2	(17.1)		24	.39	.26
Motor	49.3	(36.4)		17	48.1	(26.6)		24	.90	-.03
Communication	22.5	(16.6)		17	23.9	(13.0)		24	.77	.08
Cognitive	19.8	(13.3)		17	20.8	(8.4)		24	.77	.08
TOTAL	168.9	(105.0)		17	183.1	(85.9)		24	.64	.14
Parent Stress Index' (PSI)										
Child Related	130.1	(23.6)		17	113.6	(19.5)		24	.02	-.69
Other Related	131.9	(27.3)		17	129.2	(29.7)		24	.76	-.10
TOTAL	262.1	(45.2)		17	242.8	(44.7)		24	.18	-.43
Family Adaptation and Cohesion Evaluation Scales (FACES)										
Adaptation	23.5	(9.2)		17	21.8	(5.8)		22	.47	-.18
Cohesion	38.1	(8.4)		17	40.0	(5.7)		22	.41	.23
Family Resource Scale" (FRS)	109.9	(27.6)	33	17	113.0	(20.3)	40	23	.69	.11
Family Support Scale" (FSS)	28.4	(11.4)	51	17	32.0	(12.3)	67	24	.35	.32
Family Inventory of' Life Events (FILE)	10.1	(5.3)		17	12.0	(8.1)		23	.39	.36

' Statistical analysis for BDI scores were conducted using raw scores only.

^

$$ES = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

Statistical analyses and Effect Size (ES) estimates for PSI and FILE were based on raw scores where low raw scores and positive ESs are most desirable. For ease of interpretation, the table also includes an approximate percentile based on the covariance adjusted score and the norming sample reported in the technical manuals. A low percentile score indicates low stress or a low number of stress-associated life events.

♦ Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

' No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on 645 pretests on children with disabilities collected as part of the longitudinal studies

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Several pretest differences were found across the seven reassessments. These differences were taken into consideration when determining covariates to be used in reassessment ANCOVAs. At the 90-month reassessment, one statistically significant difference was found on the PSI-child related variable. This was subsequently used as a covariate in the 90-month reassessment ANCOVAS.

Comparability of Reassessment Contextual Measures

In addition to establishing and controlling for any pretest differences found on measures of child and family functioning, there was a possibility that contextual variables which may have changed during any of the reassessment years, could have influenced the outcomes. Consequently, contextual variables were monitored throughout the project. Family demographic data (e.g., marital status, disruptive events in the family's life, family size, etc.), child health data, and access to additional therapeutic interventions were tracked using instruments developed at EIRI. The family demographic data contained in Table 3.4 indicate that pretest family structural differences remained stable between the treatment groups included at each of the reassessments. Reassessment data on a global measure of children's health and hours of therapy received from non-pre-school personnel indicated that children in both groups were perceived to be comparably healthy and that the ratio in which other services were received was similar to the planned home visit intensity ratio.

Table 3.11 summarizes analyses of the standardized measures used as family functioning contextual data collected at each of the reassessments. Across the six reassessments, three statistically significant findings appeared, all of which indicated more favorable conditions related to family functioning in the standard intervention group, none of which occurred at the 90-month reassessment: at the 18-month reassessment the standard group scored statistically significantly better on the FSS, at the 42-month reassessment the same group

Table 3.11

Comparison of Contextual Variables in the Arkansas Intensity Study

		Standard Intensity					Expanded Intensity							
Variable	Covariate◆	x̄	(SD)	Adj.x̄	%ile	n	x̄	(SD)	Adj.x̄	%ile	n	ANCOVA F	p Value	ES
8-MONTH REASSESSMENT														
Family Resource Scale** (FRS)	1	113.0	(23.0)	112.8	40	28	115.5	(20.5)	115.7	48	37	.84	.36	.13
Family Support Scale** (FSS)	2	29.5	(14.1)	29.5	57	28	28.0	(13.8)	28.1	50	37	.29	.60	-.10
Family Index of Life Events* and Changes (FILE)	1,3	7.8	(6.1)	8.9	47	28	11.3	(6.6)	10.3	40	34	1.36	.25	.28
18-MONTH REASSESSMENT														
Family Resource Scale** (FRS)	1	114.2	(26.8)	114.8	43	25	114.8	(16.0)	114.1	41	29	.03	.86	-.03
Family Support Scale** (FSS)	2	35.1	(15.7)	35.0	72	25	27.3	(11.1)	27.4	47	32	6.41	.01	-.48
Family Index of Life Events and Changes (FILE)	1,3	8.1	(7.2)	9.5	40	24	9.9	(7.7)	8.6	47	30	.41	.53	-.13
30-MONTH REASSESSMENT														
Family Resource Scale** (FRS)	1	119.7	(24.3)	120.4	54	22	115.1	(17.6)	114.4	41	34	1.55	.22	-.25
Family Support Scale** (FSS)	2	29.5	(14.4)	9.4	54	21	27.9	(12.2)	28.0	50	34	.20	.66	-.10
Family Index of Life Events and Changes (FILE)	1,3	7.2	94.9)	7.9	55	19	10.3	(8.10	9.7	40	32	1.08	.30	-.39
42-MONTH REASSESSMENT														
Family Resource Scale** (FRS)	1	120.6	(20.6)	120.8	55	24	114.8	(23.6)	114.6	43	33	1.26	.27	-.31
Family Support Scale** (FSS)	2	32.2	(15.6)	32.3	66	23	28.7	(13.9)	28.6	54	27	1.03	.32	-.11
Family Index of Life Events and Changes (FILE)	1,3	6.2	(4.5)	6.3		21	9.0	(5.4)	8.9		30	3.59	.06	-.58
66-MONTH ASSESSMENT														
Family Resource Scale** (FRS)		120.1	(22.8)		54	18	120.0	(14.7)		54	29	.02	.98	-.00
Family Support Scale** (FSS)		31.2	(13.7)		63	18	29.0	(12.1)		54	29	.33	.57	-.16
Social Readjustment Rating* Scale (SRRS)														
Stress		117.4	(87.9)			18	151.2	(105.2)			29	1.29	.26	.38
Primary Negative Events		14.2	(22.3)			18	43.0	(58.0)			29	4.03	.04	1.29
78-MONTH ASSESSMENT														
Family Resource Scale** (FRS)		124.1	(17.6)		61	17	120.0	(20.7)		54	29	.46	.50	-.23
Family Support Scale** (FSS)		34.2	(17.7)		71	17	29.1	(10.8)		55	29	1.48	.23	-.29
Social Readjustment Rating* Scale (SRRS)														
Stress		100.6	(95.1)			17	135.3	(93.4)			29	1.46	.23	.36
Primary Negative Events		14.9	(33.8)			17	33.7	(46.4)			29	2.12	.15	.56
90-MONTH ASSESSMENT														
Family Resource Scale** (FRS)		124.1	(33.7)		41	16	123.0	(20.5)		59	24	1.07	.31	.26
Family Support Scale** (FSS)		36.9	(13.7)		78	14	30.0	(12.4)		59	24	2.52	.12	-.50
Social Readjustment Rating* Scale (SRRS)														
Stress		157.3	(77.0)			16	152.4	(159.9)		59	24	.01	.91	.06
Primary Negative Events		54.4	(62.7)			16	34.9	(55.2)			24	1.08	.31	-.31

$$ES = \frac{\text{Expanded Intensity } \bar{x} - \text{Standard Intensity } \bar{x}}{\text{Standard Intensity SD}}$$

* Statistical analyses and Effect Size (ES) estimates for SRRS and FILE were based on raw scores where low raw scores and positive ESs are most desirable. For ease of interpretation, the table also includes an approximate percentile based on the covariance adjusted score and the norming sample reported in the technical manuals. A low percentile score indicates low stress or a low number of stress-associated life events.

◆ Analyses for the FSS and FRS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better.

* No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on 645 pretests on children with disabilities collected as part of the longitudinal studies

* Covariates: 1 = FRS total (pretest), 2 = FSS (pretest), 3 = FILE (pretest)

significantly better on the FILE, and at the 66-month reassessment on the Primary Negative Events score of the Social Readjustment Rating Scale. The latter finding was reexamined by repeating the analysis without two outliers. This analysis resulted in there no longer being a statistically significant difference. One outlier existed on the stress factor on the SRRS at the 90-month reassessment. When the analysis was repeated without this outlier, no statistically significant differences were still found. Overall, the contextual data suggest a sustained comparability of the two intervention groups with a few exceptions. Though some differences on the contextual variables appeared, they varied from reassessment to reassessment indicating no real pattern and suggesting that they may have been random fluctuations. Had a pattern emerged indicating a consistent contextual advantage to the standard intervention group, this may have explained the pattern of no difference on outcome measures consistently found at each of the reassessments. Therefore, it is likely that contextual data did not influence the interpretation of reassessment findings, although these data will continue to be examined for emerging patterns in the future.

Measures of Child Functioning

Results of the reassessments are contained in Table 3.12. All reassessment data were analyzed using Analysis of Covariance (ANCOVA) procedures. These procedures are useful for two purposes: (a) to increase the statistical power of a study by reducing error variance; and (b) to adjust for any pretreatment differences which were present between the groups. In either application, the degree to which ANCOVA is useful depends on the correlation between the covariate(s) selected and the outcome variable for which analyses are being done. However, since one degree of freedom is lost for each covariate used, it is

Table 3.12

Reassessment Measures of Child Functioning for Alternative Intervention Groups for Arkansas

		Standard Intensity				Expanded Intensity						
Variables	Covariates◆	x	(SD)¯	Adj.x	n¯	x	(SD)¯	Adj.x	n	ANCOVA F	P Value	ES
8-Month Reassessment (CA in months)		35.6	(14.2)	29	35.5	(12.3)	38	.09	.97	.01		
Battelle Developmental Inventory'												
(BDI) Raw Scores for:												
Personal-Social	I	56.8	(34.8)	61.1	29	62.9	(26.3)	58.6	38	.46	.50	-.07
Adaptive Behavior	I	41.9	(25.9)	45.1	29	45.6	(18.0)	42.4	38	1.56	.22	-.10
Motor	I	57.7	(20.6)	62.6	29	66.5	(29.7)	61.5	38	.09	.76	-.03
Communication	I	27.5	(20.6)	29.8	29	33.2	(12.5)	30.9	38	.29	.59	.05
Cognitive	I	25.2	(17.6)	27.2	29	25.7	(11.4)	23.7	38	3.13	.08	-.20
TOTAL	I	209.1	(131.8)	225.8	29	233.9	(91.6)	217.2	38	.73	.40	-.07
SICD Age Discrepancies												
Receptive Communication	I	-14.6	(10.2)	-13.4	28	-12.7	(10.7)	-13.9	38	.12	.79	-.05
Expressive Communication	I	-17.0	(9.6)	-15.8	28	-15.0	(12.5)	-16.2	38	.15	.85	-.04
Vineland DQs												
Communication Domain	I	49.7	(28.1)	52.6	24	57.4	(29.2)	54.5	31	.09	.77	.07
Daily Living Domain	I	55.2	(28.3)	58.2	24	59.6	(27.8)	56.5	31	.09	.76	-.06
Socialization Domain	I	49.9	(30.3)	52.7	24	57.6	(25.9)	54.8	31	.13	.72	.07
18-Month Reassessment(CA in months)		46.7	(15.0)		26	44.9	(11.6)		35	.74	.58	-.12
Battelle Developmental Inventory'												
(BDI) Raw Scores for:												
Personal-Social	I	75.2	(42.6)	78.2	26	84.5	(35.7)	81.4	35	.21	.65	.05
Adaptive Behavior	I	50.4	(28.1)	52.8	26	53.5	(21.8)	51.1	35	.43	.51	-.06
Motor	I	68.8	(45.6)	72.3	26	74.1	(33.0)	70.6	35	.12	.72	-.04
Communication	I	35.8	(23.8)	37.7	26	40.3	(19.1)	38.4	35	.06	.81	.02
Cognitive	I	29.8	(20.7)	31.4	26	31.8	(14.9)	30.2	35	.36	.55	-.06
TOTAL	I	260.1	(152.6)	272.9	26	284.2	(116.2)	271.4	35	.01	.91	-.01
SICD Age Discrepancies												
Receptive Communication	I	-19.1	(13.7)	-18.7	24	-15.7	(14.6)	-16.1	30	.47	.50	.19
Expressive Communication	I	-23.0	(13.6)	-22.7	24	-13.7	(18.8)	-14.1	30	3.62	.06	.29
Vineland DQs												
Communication Domain	I	48.9	(29.1)	50.8	24	55.8	(26.6)	54.0	31	.31	.58	.11
Daily Living Domain	I	55.0	(33.8)	56.9	24	60.4	(26.0)	58.4	31	.06	.81	-.04
Socialization Domain	I	49.7	(27.5)	51.1	24	55.6	(23.3)	54.3	31	.29	.59	.12
30-Month Reassessment(CA in months)		60.6	(15.1)		22	57.4	(13.0)		34	1.35	.43	.21
Battelle Developmental Inventory'												
(BDI) Raw Scores for:												
Personal-Social	I	88.0	(51.4)	89.8	22	100.4	(40.3)	98.5	34	1.23	.27	.17
Adaptive Behavior	I	56.5	(32.7)	57.8	22	64.9	(25.1)	63.5	34	1.91	.12	.17
Motor	I	77.7	(52.1)	79.9	22	87.1	(39.6)	84.9	34	.72	.40	.10
Communication	I	44.8	(29.4)	46.0	22	47.3	(24.9)	47.1	34	.08	.78	.04
Cognitive	I	41.8	(32.0)	43.1	22	41.9	(24.7)	40.6	34	.38	.54	-.09
TOTAL	I	309.3	(191.2)	317.1	22	342.6	(145.2)	334.8	34	.64	.43	.09
SICD Age Discrepancies												
Receptive Communication	I	-27.4	(19.5)	-30.9	21	-24.0	(19.7)	-28.5	34	.28	.60	.12
Expressive Communication	I	-32.2	(15.6)	-31.9	21	-27.2	(19.3)	-27.4	34	.86	.36	.29
Vineland DQs												
Communication Domain	I	47.4	(27.4)	50.9	22	55.6	(30.3)	52.2	34	.62	.81	.05
Daily Living Domain	I	50.7	(27.0)	54.2	22	58.1	(29.0)	54.6	34	.01	.93	.01
Socialization Domain	I	47.1	(27.5)	50.5	22	55.1	(29.3)	51.8	34	.05	.82	.05
42-Month Reassessment(CA in months)		70.9	(16.2)		22	67.3	(13.2)		33	.92	.40	.22
Battelle Developmental Inventory'												
(BDI) Raw Scores for:												
Personal-Social	I	103.5	(47.1)	104.1	24	109.9	(41.2)	109.2	33	.38	.54	.11
Adaptive Behavior	I	66.8	(29.6)	67.2	24	67.7	(24.9)	67.2	33	.00	.99	.00
Motor	I	91.8	(51.4)	92.6	24	92.4	(40.2)	91.6	33	.02	.89	-.02
Communication	I	51.5	(30.5)	52.0	24	55.8	(26.9)	55.3	33	.48	.49	.10
Cognitive	I	49.7	(33.8)	50.2	24	48.8	(27.5)	48.3	33	.18	.67	-.06
TOTAL	I	359.1	(188.0)	362.1	24	374.5	(149.6)	371.1	33	.14	.71	.05
Vineland DQs												
Communication Domain	I	49.7	(28.1)	50.0	24	56.6	(29.6)	56.3	33	.88	.35	.22
Daily Living Domain	I	55.2	(28.3)	55.5	24	58.3	(29.2)	58.2	33	.17	.69	.10
Socialization Domain	I	49.9	(30.3)	50.2	24	56.5	(26.5)	56.2	33	.83	.37	.20

' Statistical analysis for BDI scores were conducted using raw scores only.

Effect Size (ES) is defined here as the difference between the group (Expanded minus Standard) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size).

◆ Covariate: I = Pretest BDI Total Raw Score

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Table 3.12 (continued)

Reassessment Measures of Child Functioning for Alternative Intervention Groups for Arkansas

		Standard Intensity				Expanded Intensity						
Variables	Covariates*	x	(SD)	Adj.x	n	x	(SD)	Adj.x	n	ANCOVA F	P Value	ES
66-Month Reassessment (CA in months)		95.2	(16.1)		18	94.1	(13.7)		29	.25	.80	-.07
Woodcock-Johnson Test of Achievement--Revised (WJ-R)												
Broad Knowledge	1,2	453.1	(19.2)	159.0	14	459.7	(23.1)	453.8	23	.81	.37	-.27
Skills Total	1,2	412.9	(47.2)	423.9	14	415.3	(49.2)	404.3	23	1.88	.18	-.42
Scales of Independent Behavior (SIB)												
Motor Skills	1,2	406.1	(80.2)	417.7	19	434.3	(55.6)	422.7	29	.18	.67	.06
Social Communication Skills	1,2	431.9	(52.6)	440.1	19	450.0	(34.3)	441.9	29	.08	.78	.22
Personal Living Skills	1,2	437.1	(46.7)	444.2	19	452.3	(34.5)	445.1	29	.02	.89	.02
Community Living Skills	1,2	416.0	(41.2)	423.2	19	424.6	(36.4)	417.4	29	.95	.34	-.14
TOTAL	1,2	422.9	(53.6)	431.4	19	440.4	(38.6)	431.9	29	.01	.94	.01
Social Skills (SSRS)												
Parent Evaluation of:												
Social Skills	1	35.7	(15.7)	35.8	16	42.3	(18.8)	42.3	28	1.59	.22	.41
Problem Behaviors	1,2	12.3	(9.8)	13.2	17	14.1	(6.5)	13.2	27	.00	.99	.00
Teacher Evaluation of:												
Social Skills	1	29.9	(8.7)	30.2	16	34.6	(10.5)	34.3	20	1.60	.12	.47
Problem Behaviors	1	11.3	(7.4)	11.7	16	14.3	(7.0)	13.9	21	.99	.33	.29
Inferred Self-Concept Scale (ISCS)	1	117.1	(9.1)	116.7	16	116.7	(13.5)	117.1	21	.01	.99	.04
78-Month Reassessment (CA in months)		105.5	(15.6)		17	106.1	(13.7)		29	-.13	.90	.04
Woodcock-Johnson Test of Achievement--Revised (WJ-R)												
Broad Knowledge	1,2	456.2	(21.5)	463.9	13	466.9	(24.3)	459.1	23	.47	.50	-.22
Skills Total	1,2	411.7	(50.7)	423.2	13	433.7	(42.6)	422.2	23	.00	.95	-.02
Scales of Independent Behavior (SIB)												
Motor Skills	1,2	406.4	(83.1)	420.6	17	440.2	(57.8)	426.0	29	.14	.71	.07
Social Communication Skills	1,2	438.0	(44.3)	447.7	17	453.4	(39.4)	443.7	29	.33	.57	-.09
Personal Living Skills	1,2	441.1	(50.2)	450.7	17	455.1	(37.1)	445.6	29	.44	.51	-.10
Community Living Skills	1,2	417.5	(42.9)	426.7	17	430.9	(38.2)	421.7	29	.48	.49	-.12
TOTAL	1,2	425.8	(53.7)	436.5	17	445.0	(41.6)	434.4	29	.07	.79	-.04
Social Skills (SSRS)												
Parent Evaluation of:												
Social Skills	1	35.2	(19.7)	36.8	16	43.6	(19.3)	42.1	28	.85	.36	.27
Problem Behaviors	1	10.2	(6.6)	10.4	17	14.8	(14.8)	14.6	29	4.15	.05	.64
Teacher Evaluation of:												
Social Skills	1	34.3	(11.2)	34.9	13	33.1	(13.1)	32.5	27	.35	.56	-.21
Problem Behaviors	1	9.7	(5.2)	10.0	13	13.8	(7.6)	13.5	27	2.31	.14	.67
Inferred Self-Concept Scale (ISCS)	1	118.0	(14.1)	117.6	13	114.6	(14.4)	115.0	27	.28	.60	-.18
90-Month Reassessment (CA in months)		118.4	(16.3)		17	118.4	(13.4)		24	.00	.99	.00
Woodcock-Johnson Test of Achievement--Revised (WJ-R)												
Broad Knowledge	1,2,3	468.9	(19.2)	473.7	14	468.3	(29.0)	463.4	18	1.71	.20	-.54
Skills Total	1,2,3	440.3	(35.5)	446.8	14	442.1	(41.5)	435.6	18	.68	.42	-.32
Scales of Independent Behavior (SIB)												
Motor Skills	1,2,3	429.7	(79.4)	435.5	17	435.3	(58.0)	429.6	24	.14	.71	-.07
Social Communication Skills	1,2,3	450.4	(41.8)	453.4	17	456.5	(43.3)	453.3	24	.00	.97	-.00
Personal Living Skills	1,2,3	452.6	(51.0)	456.8	17	457.3	(40.0)	453.1	24	.15	.70	-.07
Community Living Skills	1,2,3	442.5	(48.2)	446.9	17	438.8	(40.7)	434.4	24	2.36	.13	-.26
TOTAL	1,2,3	443.8	(53.5)	448.8	17	444.6	(41.8)	439.6	24	.93	.34	-.17
Social Skills (SSRS)												
Parent Evaluation of:												
Social Skills	1,2,3	41.5	(19.9)	43.3	17	46.6	(18.5)	44.8	24	.09	.76	.08
Problem Behaviors	1,2,3	14.3	(9.0)	13.9	17	14.8	(4.5)	15.2	24	.34	.57	.14
Teacher Evaluation of:												
Social Skills	1,2	28.3	(13.1)	29.1	16	33.0	(12.4)	32.2	24	.79	.38	.24
Problem Behaviors	1,2	10.6	(5.3)	11.0	16	14.5	(6.5)	14.5	24	3.10	.09	.66
Inferred Self-Concept Scale (ISCS)	1,2	117.5	(14.0)	116.9	16	110.0	(17.5)	110.6	24	1.51	.23	-.45

Effect Size (ES) is defined here as the difference between the group (Expanded minus Standard) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation (see Glass, 1976/ Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size).

* Covariate: 1 = Pretest BDI Total Raw Score, 2 = Child's Chronological Age at Pretest, 3 = PSI Child related

generally best to use a limited number of covariates in any given analysis. All pretest and demographic variables were considered as potential covariates. The final selection of covariates depended on a judgement of which variable or set of variables could be used to maximize the correlation or multiple correlation with the outcome variable in question and still include those demographic or pretest variables for which there are the largest pretreatment differences. In each analysis, the specific covariates are indicated in the table.

Battelle pretest data (in each domain) were the best predictors of Battelle reassessment scores, with correlations ranging between .67 and .96 ($p < .001$). Regression analyses indicated that when the BDI total raw score was used as a correlate of child functioning measures, other variables, including family data, did not account for a statistically significant additional amount of variance in outcome measures.

No statistically significant mean differences were found on any of the child measures at any of the reassessments except that the standard intervention group outperformed the expanded group in the cognitive domain of the BDI at 8-month reassessment and the expanded group outperformed the standard group on the expressive communication score of the SICD at the 18-month reassessment (see Table 3.12). Although some fairly strong positive effect sizes were found in two BDI subdomains and one Vineland subdomain at 30-month reassessment, these differences disappeared at the 42-month reassessment, suggesting that they may have been random variations.

Results of the 66-month, 78-month, and 90-month reassessments (including only cohort 1) also appear in Table 3.12. Consistent with earlier analyses, the Pretest BDI total scores were the best predictors of all child functioning measures used at these reassessments. Additionally, the child's chronological age at pretest was a significant predictor. No statistically significant difference on the Woodcock-

Johnson, the Scales of Independent Behavior, the Social Skills Rating Scale, or the Inferred Self-Concept Scale were found at the 66-month, 78-month, or 90-month reassessments. Because the Social Skills Rating Scale and the Inferred Self-Concept Scale were designed for young elementary-age children, and because the population in this study ranged widely in their development, there was some concern that items on these scales (both of the which were inferred measures completed by teachers and parents), were not necessarily appropriate for children functioning below the age-five level. Therefore, a second analysis was conducted on the SSRS and the Inferred Self-Concept Scale excluding children whose age equivalent scores on the Total SIB were below 5 years. Results from these analyses were consistent with the initial findings; hence, Table 3.12 includes all children who completed those measures, regardless of the age-equivalent scores on the SIB.

Measures of Family Functioning

Reassessment analyses of family functioning measures are presented in Table 3.13. Analysis of reassessment data indicated that some PSI differences were statistically significant (i.e., other related stress at the 30-month reassessment, and all PSI domains at the 42-month reassessment). Analysis of the family functioning data from the 66-month and 78-month reassessments (including only cohort 1) indicated no statistically significant differences on the PSI, PSAS, or the Teacher Ratings of Parent Participation. Covariates used in these analyses included total stress scores, family cohesion scores, and total family resource scores at pretest, and critical life events (FILE) at reassessment. No statistically significant differences were found on the family measures at the 90-month reassessment.

As a part of the 78-month reassessment, parents were asked to complete an additional questionnaire which elicited their reflective evaluation of their early intervention experience. Parents were first asked how they felt about the number

Table 3.13

Reassessment Measures of Family Functioning for Alternative Intervention Groups for Arkansas Intensity Study

		Standard Intensity					Expanded Intensity							
Variable	Covariate◆	x	(SD)	Adj.x	%ile	n	x	(SD)	Adj.x	%ile	n	ANCOVA F	P Value	ES
8-Month Reassessment														
Parent Stress Index (PSI)'*														
Child Related	1,2,3	116.7	(26.6)	117.4	86	26	116.2	(22.4)	115.5	82	31	.15	.71	.07
Other Related	1,2,3	129.0	(30.9)	131.4	68	26	134.5	(28.2)	132.2	68	31	.03	.86	-.03
TOTAL	1,2,3	245.7	(53.5)	248.7	79	26	250.7	(43.9)	247.7	78	31	.02	.89	.02
Family Adaptation and Cohesion Evaluation Scale (FACES)														
Adaptability (range 20 to 50)	4	21.8	(6.1)	21.4		29	21.4	(5.3)	21.8		36	.13	.72	.07
Cohesion (range 20 to 50)	5,2	38.9	(7.3)	38.7		29	40.0	(5.0)	40.2		35	1.76	.19	.21
18-Month Reassessment														
Parent Stress Index (PSI)'*														
Child Related	1,2,3	113.3	(28.6)	114.4	80	24	117.2	(27.2)	116.0	85	29	.07	.63	-.06
Other Related	1,2,3	124.6	(31.9)	126.2	60	24	137.1	(25.9)	135.5	73	29	3.00	.09	-.28
TOTAL	1,2,3	234.5	(53.7)	237.0	68	24	258.1	(47.1)	255.6	84	29	3.64	.06	-.35
Family Adaptation and Cohesion Evaluation Scale (FACES)														
Adaptability (range 20 to 50)	4	20.7	(6.4)	20.4		26	22.2	(6.7)	22.4		33	1.41	.24	.25
Cohesion (range 20 to 50)	5,2	38.1	(7.9)	37.8		26	38.2	(6.2)	38.6		33	.33	.57	.05
30-Month Reassessment														
Parent Stress Index (PSI)'*														
Child Related	1,2,3	111.4	(26.7)	113.0	79	20	121.1	(29.0)	119.4	87	26	1.10	.30	-.24
Other Related	1,2,3	118.2	(26.5)	121.2	50	20	139.6	(32.9)	136.6	75	26	5.90	.02	-.58
TOTAL	1,2,3	228.8	(51.2)	233.2	65	20	256.8	(58.3)	252.5	82	26	3.04	.09	-.39
Family Adaptation and Cohesion Evaluation Scale (FACES)														
Adaptability (range 20 to 50)	4	19.9	(5.2)	19.7		22	21.0	(6.0)	21.2		32	1.19	.28	.29
Cohesion (range 20 to 50)	5,2	38.5	(6.7)	38.7		22	38.4	(5.8)	38.1		32	.14	.71	-.09
42-Month Reassessment														
Parent Stress Index (PSI)'														
Child Related	1,2,3	107.9	(20.8)	106.8	71	19	119.5	(30.9)	120.6	89	22	4.49	.04	-.66
Other Related	1,2,3	117.7	(33.9)	120.7	50	19	132.8	(33.5)	129.8	66	22	1.42	.24	-.27
TOTAL	1,2,3	226.1	(59.7)	228.1	60	19	252.9	(58.1)	250.9	81	22	3.74	.06	-.38
Family Adaptation and Cohesion Evaluation Scale (FACES)														
Adaptability (range 20 to 50)	4	22.2	(8.5)	21.5		22	20.9	(5.4)	21.6		25	.00	.98	.01
Cohesion (range 20 to 50)	5,2	38.3	(9.0)	38.5		22	40.8	(5.1)	40.6		25	1.16	.29	.23

(continued)

Effect Size (ES) is defined here as the difference between the group (Expanded minus Standard) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation (see Glass, 1976/ Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size).

' Statistical analyses and Effect Size (ES) estimates for PSI were based on raw scores where low raw scores and positive ESs are most desirable. For ease of interpretation, the table also includes an approximate percentile based on the covariance adjusted score and the norming sample reported in the technical manuals. A low percentile score indicates low stress.

* No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on all pretests collected as part of the longitudinal studies (currently, 645 families with handicapped children).

◆ Covariates: 1 = PSI Total (pretest);2 FRS total (pretest); 3 = FILE (posttest); 4 = FACES Adaptability (pretest); 5 = FACES Cohesion (pretest)

Table 3.13 (continued)

Reassessment Measures of Family Functioning for Alternative Intervention Groups for Arkansas Intensity Study

		Standard Intensity					Expanded Intensity				ANCOVA	P		
Variable	Covariate◆	x	(SD)¯	Adj.x	%ile	n¯	x	(SD)¯	Adj.x	%ile	n	F	Value	ES
66-Month Reassessment														
Parent Stress Index (PSI) Short Form														
Parent Distress	1	27.5	(10.8)	26.6	60	18	26.4	(9.5)	27.4	60	29	.07	.79	.07
Parent/Child Dysfunction	1	26.2	(8.1)	25.5	85	18	22.2	(5.8)	22.9	70	29	2.00	.17	.32
Difficult Child	1	29.6	(10.5)	28.6	70	18	29.6	(9.8)	80.6	80	29	.53	.47	.19
TOTAL	1	83.3	(26.4)	80.7	80	18	78.2	(21.6)	80.8	80	29	.00	.99	.00
Parent Self-Awareness Scale	1	41.6	(8.7)	42.2		18	44.9	(11.6)	44.3		29	.44	.51	.24
Teacher Rating of Parent Participation														
Knowledge/ Understanding	6,7	8.2	(2.7)	8.6		17	8.6	(2.4)	8.3		23	.17	.69	-.11
Skills/Support	6,7	13.3	(4.7)	13.9		17	16.2	(3.6)	15.6		23	1.93	.17	.35
78-month Reassessment														
Parent Stress Index (PSI) Short Form														
Parent Distress	1	26.0	(8.7)	25.2	50	17	25.9	(11.4)	26.7	60	29	.23	.64	.17
Parent/Child Dysfunction	1	25.9	(7.7)	25.3	80	17	23.8	(6.7)	24.4	75	29	.19	.66	-.12
Difficult Child	1	27.2	(7.6)	26.2	55	17	28.6	(10.1)	29.5	75	29	1.80	.19	.43
TOTAL	1	79.1	(22.0)	76.7	72	17	78.2	(23.8)	80.6	78	29	.39	.54	.18
Parent Self-Awareness Scale	**1**	**42.2**	**(9.2)**	**43.1**		**17**	**43.8**	**(11.1)**	**43.0**		**29**	**.00**	**.99**	**-.01**
Teacher Rating of Parent Participation														
Knowledge/Understanding	6,7	8.9	(3.0)	9.3		13	9.1	(2.2)	8.7		27	.64	.43	-.20
Skills/Support	6,7	14.6	(5.2)	15.3		13	15.6	(4.1)	14.9		27	.05	.82	-.08
90-month Reassessment														
Parent Stress Index (PSI) Short Form														
Parent Distress	1	29.7	(10.1)	29.3	70	17	25.8	(11.2)	26.2	55	24	.67	.42	-.31
Parent/Child Dysfunction	1	26.0	(8.3)	24.0	75	15	23.6	(6.5)	24.9	80	24	.01	.94	.11
Difficult Child	1	31.1	(10.6)	29.7	75	15	27.5	(9.0)	28.9	70	24	.06	.81	-.08
TOTAL	1	85.0	(24.7)	81.7	80	15	76.9	(23.9)	80.2	77	24	.03	.86	-.06
Teacher Rating of Parent Participation														
Knowledge/Understanding	1,2,3	13.6	(4.8)	14.6		16	15.1	(4.2)	14.2		24	.09	.76	-.08
Skills/Support	1,2,3	8.2	(2.9)	8.6		16	9.2	(2.1)	8.8		24	.07	.80	-.07

Effect Size (ES) is defined here as the difference between the group (Expanded minus Standard) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation (see Glass, 1976/ Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size).

¯ Statistical analyses and Effect Size (ES) estimates for PSI were based on raw scores where low raw scores and positive ESs are most desirable. For ease of interpretation, the table also includes an approximate percentile based on the covariance adjusted score and the norming sample reported in the technical manuals. A low percentile score indicates low stress.

* No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on all pretests collected as part of the longitudinal studies.

◆ Covariates: 1 = PSI Child related, 2 = FSS number of sources of support, 3 = Education of mother of home visits they had had per month. Responses were comparable between the two treatment groups. A total of 88.2% (15) of the parents in the standard group and 82.8% (24) of the parents in the expanded group indicated that the number they had received was "about right". Interestingly, one parent (5.9%) in the standard group indicated that they had received "far too few" home visits while 3 (13.7%) of the parents in the expanded group indicated that they had receive "somewhat" or "far too few" home visits as a part of their early intervention. When asked the ideal number of home visits for an early intervention program the two groups were also comparable; the responses in both groups ranged from 2 to 8 visits per month with a mean of 4.3 visits per month suggested by the standard group and 5.4 visits per month suggested by the expanded group.

When ask who benefitted the most from early intervention, responses between the two groups again were comparable. A total of 88.2% (15) of the parents in the standard group and 79.3% (23) of the parents in the expanded group indicated that both the child and the parent had benefitted. A total of 11.8% (2) of the parents in the standard group and 20.7% (6) of the parents in the expanded group reported that mainly the child benefitted from early intervention. None of the parents in either group indicated that mainly the parent benefitted and nor did any of the parents indicate that neither the child nor the parent had benefitted. Table 3.14 summarizes parents' perceptions of the effects of early intervention which attribute to their perception of early intervention as having "worked" for them. As can be seen in Table 3.14, no statistically significant differences were found with the exception that more parents in the standard group perceived that early intervention had helped them access other services.

Table 3.14

Parents Reflective Perceptions of the Effectiveness of Early Intervention at the 78-Month Reassessment

Standard	Expanded					
Variable	**Mean**	**n**	**Mean**	**n**	**p-value**	**ES**
Improved Child's Development	82.4%	17	82.8%	29	.88	.04
Improved Child's Health	35.3%	17	17.2%	29	.18	-.40
Provided Emotional Support for Parent	70.6%	17	65.5%	29	.78	-.08
Helped Parent(s) Understand their Child's Special Needs	88.2%	17	93.1%	29	.54	.19
Helped Parent Access Other Services	76.5%	17	48.3%	29	.08	-.52

* Percent of subjects who perceived early intervention had "worked" because of this result.

Conclusions

The results of this study do not support the hypothesis that more intense frequency of home-based early intervention visits from, twice per week compared with once per week, will result in better outcomes for participating children or families. Even though there are a few statistically significant results, the overall pattern is one of no effect. The absence of any effect is particularly important because all of the outcome measures used in this study were logically related to the type of intervention delivered.

As noted at the beginning of this report, a number of previous reviews of the early intervention research literature have concluded that more frequent delivery of services results in better outcomes for participating children. Therefore, it is important to consider why the findings of this study are contrary to that conventional wisdom.

Although no research study is perfect, this study was well-designed and seems to address all of the threats to internal validity cited by Campbell and Stanley (1963) and others. For example, children were randomly assigned to groups, and the comparability of participants on key measures that were highly related to the outcomes was documented. Analysis of covariance was used to adjust for any residual pretreatment differences and to increase the power of the design. The design/analysis combination resulted in excellent statistical power to detect moderate size differences and good power to detect small differences. Outcomes were assessed by people who were uninformed about the hypotheses of the study, and included both child and family measures that were theoretically relevant to the types of interventions delivered. Although some attrition was present, analyses showed that this had little, if any, effect on the comparison of groups. Historical threats to the internal validity of the study were examined and discounted (by verifying that contextual variables such as the receipt of additional services, disruptive family events, or serious health problems might have contaminated the results of the study). Therefore, it is reasonable to conclude that any discrepancy between conventional wisdom and this study's findings were not, at least in any simplistic way, the result of methodological weaknesses.

While the present study improved upon the methodological weaknesses of many of the earlier studies, that is not to say that methodological improvements are no longer needed. While this study attempted to examine all relevant variables on which the two types of intervention were intended to have an impact, it is possible that there were areas of differential impact which we presently do not know how to reliably measure, and which, if they were reliably measured would demonstrate that one intensity was more effective than the other. The results of a single study, or of a group of studies conducted from within a single methodological paradigm, should never be the sole basis for drawing conclusions about a phenomenon as complex as the frequency with which early intervention services should be delivered. Rather, these questions must be examined from a variety of methodological and theoretical perspectives to construct a set of viable conclusions.

This study's findings are not the only ones which have contradicted conventional wisdom. Of the six well-designed studies with children who were disabled that have directly examined the issue of frequency or intensity of intervention, only one (Lovaas, 1987) showed statistically significant differences in favor of the more intense or more frequent group. The other five (Barnett & Pezzino, 1987; Sandow et al., 1981; Jenkins et al., 1982; Law, 1991; and Taylor et al., 1984) concluded that there was no advantage to more frequent or more intensive interventions. All of these researchers seemed surprised by a finding of no difference and concluded with calls for further research on this topic. We agree. Further research is important. But, it is also important to emphasize that the results of this study are not totally inconsistent with the results of previous research which has directly examined the intensity hypothesis.

The results of the Lovaas (1987) study suggest another possibility which must be considered when interpreting the findings of this study. Lovaas reported a substantial difference between autistic children who received 40 hours per week of 1:1 services compared to another group of autistic children who received only 10 hours per week of intervention (average ES = 1.41). Although the Lovaas study was not as rigorously designed as the one reported here (children were not randomly assigned to groups, analysis of covariance was not used, diagnosticians were not "blind," treatment verification techniques were not reported), it was a reasonably well-designed study. It is possible that the dramatically different results between Lovaas' findings and those reported from this study may have been the result of the substantially larger differences in intensity that were present in that study (40 vs. 10 hours per week) compared to this study (2 vs. 1 hour per week).

Many people seem to expect that early intervention with children having disabilities will accomplish dramatic results with relatively modest expenditures. In reality, it may well be that the relationship between input and outputs is more consistent with what is depicted in Figure 1. If such a relationship exists, it is not surprising that this study (as well as the others cited above) found no differences between groups. All of these studies (i.e., the present study, Barnett

& Pezzino, 1987; Jenkins et al., 1982; Law et al., 1991; Sandow et al., 1981; Taylor et al., 1984) made comparisons that fell within the shaded area of Figure 1. The lack of effect for those comparisons could be explained by the fact that the slope of the relationship is horizontal in that entire range. For there to be substantial benefits associated with increasing the frequency of the intervention is to the intensity of intervention, we may have to make comparisons in which the more intensive intervention is to right of the shaded area. Because most previous studies with children who have disabilities have not made those comparisons, it may appear as if more intense interventions are not beneficial, when in fact it is merely a function of not having broken through the "threshold" which is necessary to achieve results.

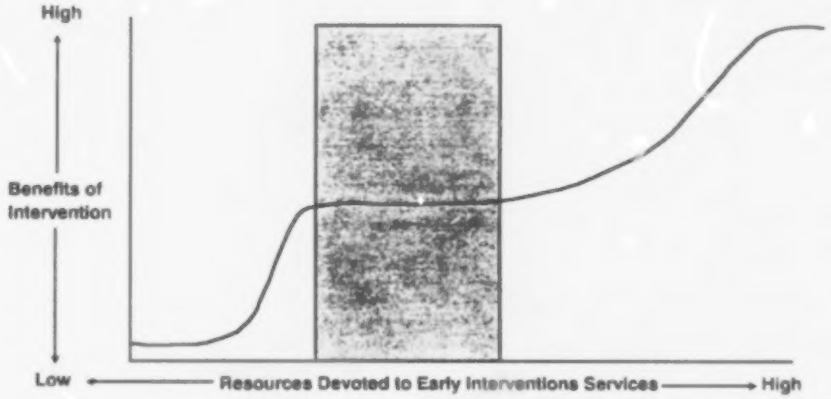


Figure 1. Hypothetical Relationship Between Resources to Early Intervention and Benefits for Participants.

Conclusions

The results of this study add to a growing body of research literature which suggests that increasing the frequency or intensity of intervention for children with disabilities, within the range of current practice, may not have a demonstrable effect. Those findings are important for parents, service providers, and researchers. For parents, it is important to be clear that the results of this study do not suggest that early intervention is unimportant or does not result in benefits. The purpose of this study was to examine the effects of increasing the frequency of intervention, not an evaluation of whether early intervention was beneficial. Although a no-treatment control group was not included in this study, previous work such as that by Sandow et al. (1981) does provide support for the concept that some intervention is better than no intervention. Furthermore, children in both groups made substantial progress from pretest to each of the subsequent reassessments.

Under Public Law 99-457, all children with disabilities are guaranteed the right to an appropriate early intervention program. Thus, the question is not whether or not early intervention ought to be provided, but instead what type of intervention is best for which children. These data suggest that increasing the frequency of this type of home-based early intervention program from 1 to 2 visits per week does not result in benefits for participating children and parents. Whether such benefits would have been achieved by designing a different type of intervention program, or by further increasing the frequency or intensity of the intervention, is a question which will require more research. As noted by Public Law 99-457, parents are essential partners in the early intervention enterprise, and hopefully their insights and experiences can be considered and incorporated as researchers design and evaluate those types of intervention programs.

For people providing services to these types of children, the results suggest that if the choice is between increasing the frequency of home-based intervention from 1 to 2 times per week and increasing the number of children to be served by a 1 time per week home-based early intervention program, the latter choice may make the most sense. As demonstrated by the cost analysis reported herein, substantial resources are required for increasing the frequency of home visits from one to two times per week. For a program similar to that described here, those resources are probably best used to serve additional children.

Of course, there may be alternative ways to provide early intervention which is more efficient than the intervention used in this study. That possibility needs to be examined, but the results of this study demonstrate that "common sense expectations" may not be fulfilled. Therefore, in designing and testing alternative types of interventions, it is critical that they be subjected to rigorous evaluations to determine whether they really are better than current practice.

For researchers, the results of this study suggest the need for further examination of this topic. In addition to studies which replicate the findings of this study in examining comparisons such as once vs. twice or once vs. three times per week, it is also important to systematically test the threshold hypothesis to determine whether much more intensive interventions would result in demonstrable benefits. In doing that, however, it is critical that research be rigorously designed so that threats to the internal validity of those studies can be controlled.

The findings of this study may be used to support the argument that options pertaining to intensity be provided, compared and contrasted, and that prescriptions or even strong recommendations regarding any single level of intensity for a particular family be avoided. When randomly assigned to two different intensities of intervention, each group improved substantially as a result of their respective interventions, though no significant longitudinal differences were observed between the groups. Thus, these findings suggest that neither high nor low intensity of intervention may be categorically considered a recommended practice. To the contrary, the present findings may illustrate the futility in attempting to approximate a "recommended" intensity level of home-based intervention which may be applied to most or all families with young children who have disabilities. Further, the present findings suggest that optimal effects may be achieved by very different intensities of service, depending on many different conditions; all of which parents, practitioners and research should be mindful as the issue of intensity continues to be scrutinized from many different perspectives.

JORDAN SCHOOL DISTRICT

Project #4

COMPARISON: Children with Mild to Severe Disabilities--Participation in a 3-day-per-week, center-based preschool program versus participation in an enhanced 5-day-per-week, center-based preschool program.

SITE COORDINATOR: Chris Giacovelli, Early Intervention Program Coordinator, Jordan School District

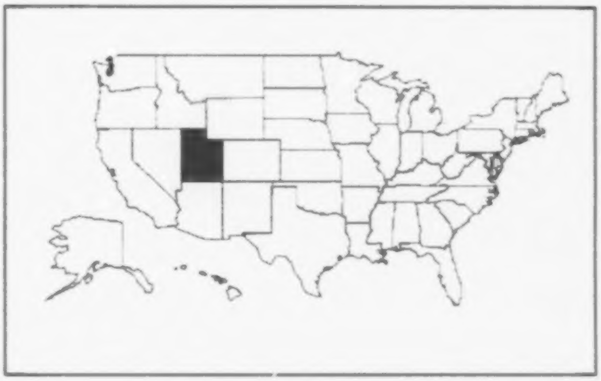
EIRI COORDINATOR: Michael Godfrey

LOCATION: Midvale, Utah

DATE OF REPORT: October 1, 1994

Rationale for the Study

Early intervention literature provides limited evidence to guide program decisions concerning the intensity of program efforts and their relative effectiveness (Casto & Mastropieri, 1986; Innocenti & White, 1991; White & Casto, 1985). Thus, it is not surprising that the frequency and intensity of services in early intervention programs varies widely--probably as a result of factors such as philosophical orientation and professional judgment of child needs.



As a result of the passage of the federal mandate to provide services to all preschool-aged children with disabilities (P.L. 99-457), the intensity of programs may change to reflect the effect of more children in programs and related funding and personnel issues. One result may be that administrators will decrease the intensity of their programs in an attempt to serve more children with the same level of funding. Conversely, the incentives created from this legislation may increase the number of individuals who advocate for increased service intensity for young children with disabilities. This could generate increased financial support which might result in more intensive programs being offered to such children.

If children and families are to receive the best possible service, it would be better if decisions which potentially affect the benefits and costs of early intervention be made using data derived from systematically controlled studies--as well as other factors. This study will help provide information for this data base by comparing two common intensity levels of intervention services for preschool-aged children with disabilities.

Review of Related Research

Most people involved with early intervention programs believe that more is better (Casto & Mastropieri, 1986). Unfortunately, very little systematic research has investigated whether more intensive programs are better for children or families (Bailey & Bricker, 1984; Casto & Mastropieri, 1986; White & Casto, 1985).

Table 4.1 summarizes characteristics of previous studies that directly compared center-based early intervention programs of different intensities for children with disabilities (Barnett & Pezzino, 1987; Jago, Jago, & Hart, 1984; Lovass, 1987; Taylor, White, & Pezzino, 1984) and two studies which made similar comparisons for children from low socioeconomic backgrounds (Blank & Solomon, 1968; Washington & Osborne, 1969). A more thorough discussion of these studies is given in Innocenti and White (1991), but a brief summary is given here.

The most intensive study, Lovass (1987), shows the greatest efficacy with an effect size of 1.41, clearly supporting the hypothesis that more intensive programs have positive results. Two of the remaining five studies show strong, positive effect sizes, while the other three are small or negative. Methodological quality ratings were based on evaluation of threats to internal validity as defined by Campbell and Stanley (1963).

Table 4.1

Studies Which Examined Intensity of Early Intervention in a Center-Based Setting

Reference	More Intensive Group	Less Intensive Group	Study Quality	Duration of Program	Child-Risk Factor	[♦]Effect Size
Barnett & Pezzino (1987)	Full-day, five-day-per-week, center-based preschool program; school district operated.	Half-day, five-day-per-week center-based preschool program; school district operated.	High	Academic year (9 months)	Disabled	-.11
Blank & Solomon (1968)[*]	Five days of individual tutoring in addition to 5-day-per-week nursery school placement.	Three days of individual tutoring in addition to 5-day-per-week nursery school placement.	Medium	45 days (9 weeks)	Disadvantaged	.57
Lovass (1987)[*]	Forty hours of one:one behaviorally oriented treatment per week (treatment carried out in home, school, and community).	Ten hours of one:one behaviorally oriented treatment per week (treatment carried out in home, school, and community).	Medium	2 years, up to 6 years (child dependent)	Disabled	1.41
Jago, Jago, & Hart (1984)[*]	Two mornings per week of center-based activities focused on language development and total communication. Parents were involved one morning per week.	One morning per week of center-based activities focused on social and self-help skills.	Low	7 months	Disabled	.15
Taylor, White, & Pezzino (1984)	Full-day, five-day-per-week center-based preschool program, school district operated.	Half-day, five-day-per-week center-based preschool program, school district operated.	High	9 months	Disabled	.10
Washington & Osborne (1969)[*]	Half-day school district kindergarten five-days-per-week, plus half-day center program focused on academic skills 5-days-per-week.	Half-day school district kindergarten five-days-per-week.	Medium	9 months	Disadvantaged	.80

[*] Studies also included nonintervention or combined intervention groups. These other groups are not included here.

[♦] Effect size is the average effect size across all dependent measures reported in the study.

The two studies which were rated highest on methodological quality have opposite signs and relatively low effect sizes. The authors of both of these studies, however, point out potential confounds in the intensity comparisons (i.e., "longer is not necessarily more"). The comparison in the Taylor, et al. (1984) study was a full vs. half-day intensity difference, but it was noted that the second half of the full-day intervention included activities like nap and lunch. The Barnett and Pezzino (1987) intervention comparison was organized in a similar way. Consequently, there may not have been twice as much time spent in instructional activities in the full-day program as in the half-day programs.

The two studies with disadvantaged children were rated of medium methodological quality and show moderately large effect sizes. However, it is unclear whether the results of studies done with disadvantaged children should be generalized to children with disabilities since there were so many differences between the two groups. The Jago, et al. (1984) study was of low methodological quality. The Lovass (1987) study showed incredibly positive results for one subgroup of children with disabilities. However, it has not yet been replicated and the intensity of the intervention received by the high-intensity group was so high that it may be unrealistic to expect that it could ever be done for all children with disabilities at public expense. In the Lovaas study, the sample was representative of less than 1% of all children with disabilities. It is not clear that their results are even conceptually applicable to non-autistic children with disabilities, which make up over 99% of all children with disabilities.

It seems obvious the often-cited literature proclaiming more intensive programs are more effective is based on insufficient evidence. In drawing conclusions about whether more intensive early intervention programs will be better for children with disabilities, we are left with two well-done studies and one fairly well-done study. The two that fall in the first category showed very small effects and the well done study may not be relevant to questions about how most early intervention programs for children with disabilities should be structured. Furthermore, the results of these three studies are inconsistent. Given the importance of the question, in terms of the resources available for early intervention, as well as the potential benefits for children, this seems to be an area urgently in need of more research.

If more intensive interventions are more effective, the studies using experimental designs where the experimental group received much higher levels of service should find substantially greater differences than studies using a design with smaller intensity differences between the groups. Although such evidence is indirect, it is the type of evidence cited in some reviews of the literature. These reviews have generally concluded that more intense early intervention programs are more effective (see for example, Bryant & Ramey, 1987; and Dunst, Snyder, & Mankinen, 1989).

A more comprehensive data base to examine this hypothesis was used in a meta-analysis conducted by EIRI. This meta-analysis synthesized approximately 200 experimentally designed studies of early intervention (see Casto, White, & Taylor, 1983, for a complete discussion of this analysis). By investigating the average effect size for experimental versus control group comparisons where the total hours of intervention, the hours of intervention per week, and the duration of intervention in weeks for the experimental group were different, it should be obvious whether the results were consistent with the hypothesis that more intensive intervention programs were better. As shown in Table 4.2, differences between experimental and control groups were not greater for those studies where the experimental group was "more intense" or of "longer duration" than those studies where the experimental group was less intense or of shorter duration. Admittedly, these data may be confounded by a number of other factors (the severity of subjects participating in the studies, the types of dependent measures used, the training of the people delivering the intervention, etc.). This analysis assumes that all other variables are evenly balanced across the various categories of intensity, and this may not be the case.

Table 4.2

Average Effect Size for Different Intensity Factors From Studies Examining Early Intervention with Children with Disabilities

	Quality of Studies'			
	Good	Fair	Poor	Total
Total Hours of Intervention				
< 50	.78 (4 [2])+	1.01 (12 [3])	.89 (18 [6])	.92 (34 [10])
50 - 249	----	.08 (3 [1])	1.20 (19 [5])	1.05 (22 [6])
250 - 499	----	.54 (5 [2])	.65 (13 [8])	.62 (18 [8])
500 - 749	.66 (2 [1])	3.31 (1 [1])	.41 (21 [4])	.54 (24 [6])
750 - 999	----	----	1.16 (5 [3])	1.16 (5 [3])
1000 - 1999	.52 (2 [1])	.66 (8 [2])	.59 (7 [3])	.62 (17 [5])
≥ 2000	----	.69 (2 [1])	1.32 (6 [2])	1.16 (8 [2])
Hours of Intervention Per Week				
< 2	.78 (4 [2])	1.34 (1 [1])	1.17 (11 [4])	1.08 (16 [7])
2 - 4.9	----	.89 (16 [2])	1.03 (31 [7])	.98 (47 [7])
5 - 9.9	----	----	.53 (15 [5])	.53 (15 [5])
10 - 12.9	----	1.19 (4 [2])	.71 (11 [9])	.83 (15 [10])
13 - 19.9	.84 (6 [2])	.30 (5 [2])	.44 (22 [4])	.49 (33 [8])
20 - 39.9	.52 (2 [2])	.70 (4 [1])	.86 (5 [3])	.74 (11 [5])
≥ 40	----	----	----	----
Duration of Intervention (Weeks)				
≤ 12	.39 (8 [3])	1.44 (7 [3])	.83 (25 [10])	.85 (40 [15])
13 - 25	.13 (2 [1])	.55 (28 [4])	.83 (41 [15])	.70 (71 [19])
26 - 38	----	.57 (23 [8])	.71 (81 [27])	.68 (104 [33])
39 - 51	.65 (11 [2])	.70 (8 [2])	.96 (40 [23])	.87 (59 [26])
52 - 77	----	.64 (8 [3])	1.00 (24 [11])	.91 (32 [14])
78 - 103	----	.69 (2 [1])	.90 (13 [6])	.87 (15 [6])
≥ 104	.10 (6 [1])	.01 (7 [1])	.49 (11 [4])	.26 (24 [5])

NOTES: 'Based on threats to internal validity

+(# of effect sizes [# of studies])

No data for cell

However, even with this confound, there is little support for the hypothesis that more intensive interventions are more effective. The results of earlier studies emphasize the need for well-controlled, methodologically sound, studies to address the intensity question.

This report presents the results of an experimental versus control group early intervention intensity study. The comparison involved the cost-effectiveness and outcome of a 3-day versus a 5-day-per-week early intervention preschool program. This study is of particular importance since both levels of intensity represent typical intervention programs, and results could affect both personnel and funding issues. Because the effects of intervention on parent and family functioning have not received sufficient investigation in previous early intervention research (Casto & Mastropieri, 1986; Dunst, 1986), the impact of these different program intensities on parents and families, as well as their child, was examined.

Overview of Study

Intensity has many dimensions. For example, programs may vary on hours per day of intervention, days per week of intervention, degree of engaged learning time in which children are involved, etc. While no single study can address all intensity variations reliably, this study contrasted preschool intervention services for children participating in two different levels of intervention as defined along a number of different intensity dimensions. Children in the more intensive group received 5-days-per-week, 2-hours-per-day preschool intervention services in classrooms established to provide appropriate, child-centered services for children with disabilities. Children in the less intensive group received 3-days-per-week, 2-hours-per-day preschool intervention services in the same classroom format. The more intensive condition in this study also had a 3:1 child/teacher ratio, while a 5:1 child/teacher ratio existed for the less intensive condition classrooms. A third dimension along which intensity was different was that more intensive condition classrooms were provided with increased availability of communication and motor therapists. In practice, this increased therapy time resulted in the presence of a speech and language therapist in more intensive condition classrooms each day they were in session, while the speech and language therapists were available on an every-other-day basis for the less intensive classroom condition. Differences in program efficacy were evaluated by assessing child and family outcomes.

Method

This study was conducted in conjunction with the early intervention program of the Jordan School District, a suburb of Salt Lake City, Utah. Prior to the 1987-88 academic year, early intervention services were administered by the Utah Division of Social Services, but the intervention services were housed at a school in the Jordan District. With the passage of P.L. 99-457 and State of Utah mandates, the district assumed the financial and administrative responsibilities of early intervention for all preschoolers with disabilities living in the area. As a result, the district expanded their early intervention classrooms into the neighborhood schools while retaining their experienced staff. At the time of this study, the Jordan School District maintained early intervention classrooms at three schools. They offered a variety of intervention options, such as: home intervention, various classroom mainstream options, and placement in neighborhood child care centers.

Prior to P.L. 99-457, the early intervention program provided a 5-day-per-week, 2½ hour-per-day, classroom-based intervention service to a limited number of qualified children. Children who met both age and Utah State Office of Education developmental criteria, as explained in the recruitment section below, were placed on a waiting list, and classroom slots were filled on a first-come basis. When responsibility for preschool services was transferred to the school district, the district began serving all eligible preschoolers and providing transportation. These factors resulted in a reduced service structure providing a 3-day-per-week, 2-hour-per-day preschool program.

This change raised concerns from preschool providers, school administrators, and the parents of children with disabilities. In conjunction with the Early Intervention Research Institute (EIRI), the Jordan School District received additional funds from the Utah State Office of Education to determine whether a more intensive (and consequently, more expensive) early intervention program would result in measurable benefits for children and their families. The specific comparison was established through negotiations with all the participating agencies. Based on the amount of additional money available from the State Office of Education, the school district was directed to design a more intensive intervention program which they believed would have the greatest likelihood of benefitting children and families. They were free to vary whatever parameters (e.g., length of day, number of days per week, student:teacher ratios, availability of therapists, etc.) that they thought would have the greatest impact. This specific comparison design is described more completely in a subsequent section.

Subjects

Participating children exhibited a wide array of disabilities (e.g., cerebral palsy, Down syndrome, communication disorders). Subjects for this study came from four classrooms located at two schools (two classrooms per school). All subjects were recruited at the beginning of the 1988-89 school year. Fifty-three children (28 less intensive, 25 more intensive) between 36 and 62 months of age ($\bar{x}$ = 50 months) participated in the study. Sixteen children in the less-intensive group were male, and eight were male in the more-intensive group. The age equivalent for the children, based on the total score of the Battelle Developmental Inventory (BDI), ranged from 16 to 46 months ($\bar{x}$ = 30 months). The majority of children were mild to moderately disabled (65% of children had developmental quotients [DQs] of 65 or below; no child had a DQ lower than 40).

Recruitment. The Utah State Office of Education criteria for acceptance into the early intervention program specified that preschool-aged children were eligible for services if they demonstrated a delay from the norm of -1.5 or greater standard deviations in three developmental areas, or -2.0 or greater standard deviations in two developmental areas, or -2.5 or greater standard deviation in one developmental area. Multiple assessments and evaluators were used by the school district in determining eligibility.

All the children identified as disabled at the schools where the classrooms were located were considered for participation in this study. Parents were informed by phone, by mail, or in person regarding the study. Parents were then given an informed-consent form to read and sign if they agreed to participate. The site contact person was available to answer parent questions and concerns. Approximately 5% of parents refused participation. The majority of these refusals were from parents who desired the less intensive program because their children were younger.

Assignment to groups. During the one-year intervention study period, subjects attended one of two schools, dependent on address. At each school, there were two classrooms, one of which was established as a more intensive classroom. There were two teachers, one at each school. Each teacher conducted both a less and more intensive classroom. The services were delivered during the morning or afternoon. The time was counterbalanced between the schools providing an a.m. and p.m. five-day classroom and an a.m. and p.m. less-intensive classroom.

After the children were identified, and the parents indicated a willingness to participate, the site contact sent information about the child (including a rating of degree of disability [mild, moderate, or severe] based on the initial district assessment) to the EIRI research coordinator. This information was used to place each child in a school by severity matrix (2 x 3). For subjects in each cell, there were four possible sequences of assignment (ABAB, BABA, ABBA, and BAAB; where A = the more intense group and B = the less intense group). A die was cast to determine the assignment sequence for each set of 4 children in each cell. This process was repeated for each cell of the matrix as the first child in a cell was identified.

Attrition. Fifty-three subjects were recruited to participate in this study at the beginning of the 1988-89 school year. Between reassessments 5 and 6, one subject in the less-intensive group withdrew from the study. The data from all 53 subjects will be presented through reassessment 5, when the number of subjects drops to 52.

Demographic characteristics. An analysis of the demographic characteristics of the sample is important to determine if the results can be generalized to the population. Analysis of the representative nature of the sample will be left to the reader; the initial demographics are presented below. The parents in the study averaged slightly more than a high school education and were in their early 30s. In 94% of the families, the parents were married and living together, and the mother was reported as the primary provider of child care (96%). Families had an average of two or three children, including the child with disabilities. Most fathers worked a 40-hour week in either a blue collar or technical/ managerial position; mothers did not work or held part-time jobs. The average family income was $30,000. All the families spoke English as their primary language, and the majority (94%) were Caucasian.

Initial statistically significant differences ($p < .10$)[1] existed between the groups on several demographic variables (see Table 4.3). Because children were randomly assigned to groups it is not surprising there were a few initial differences between the groups in demographic characteristics. These differences are important because if the two groups were initially different on important aspects of the study, the outcome may be a function of the initial differences, not the intervention. By using analysis techniques which account for initial differences between the groups we can be more confident that differences between the groups on outcome variables can be attributed to the differences in the intervention techniques.

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[1] *As discussed further in the Results section, alpha for all statistical tests was set at* $p \leq .10$ *in order to increase statistical power and balance Type I and Type II errors.*

Table 4.3

Comparison of Groups at Pretest on Demographic Characteristics for Jordan Intensity Study

	Less Intensive			More Intensive				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p* Value	ES
• Age of child in months	50.4	6.8	28	50.8	6.4	25	.85	.06
• Percent male*+	57		28	32		25	.07	.59
• Percent of children who are Caucasian*	96		28	92		25	.49	.28
• Age of mother in years+	32.5	4.5	28	32.6	6.6	24	.95	.02
• Years of education for mother	12.7	1.9	28	14.1	1.9	25	.01	.74
• Percent of mothers employed outside+* the home	29		28	46		24	.20	.43
• Hours per week mother at work+	8.3	14.8	28	17.0	20.4	25	.08	.59
• Age of father in years+	35.0	4.2	28	34.9	6.0	22	.93	.02
• Years of education for father	13.8	1.8	28	14.3	2.5	24	.37	.28
• Percent of fathers employed as technical managerial or above	36		28	52		23	.24	.39
• Hours per week father employed+	40.7	15.3	28	38.6	15.5	22	.64	.14
• Total household income	$26,821	$8,572	28	$30,380	$16,764	25	.33	.88
• Percent living with mother and father*	100		28	88		44	.05	-.82
• Number of siblings+	3.1	1.9	28	2.0	1.5	25	.02	.58
• # of siblings with disabilities	.6	.8	28	.5	.9	25	.70	.13
• Percent with English as primary language*+	100		28	100		25	1.00	.00
• Percent with mother as primary caregiver*	100		26	92		24	.13	-.61
• Percent of families using child care more than 5 hours per day	11		28	36		25	.03	.78

* Based on one-way analysis of variance unless noted otherwise.

* Statistical analyses for these variables were based on chi-square analysis where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scored "0."

+ Absolute values of the Effect Size (ES) are reported. No judgment is intended.

$$\text{Effect Size} = \frac{\bar{x}\ (\text{more}) - \bar{x}\ (\text{less})}{\text{SD}\ (\text{less})}$$

(see Cohen, 1977; Glass, 1976; Tallmadge, 1977; for a more general discussion of the concept of effect size)

Another important aspect involves the variables that do not differ between the groups. For example, when measuring developmental differences, it is important to have subjects who are similar in age. In this study, subjects were roughly the same age ($\bar{x}$ = 50.6 months, sd = 6.6 months) in both the more- and less-intensive groups. The children's mothers' and fathers' ages were also comparable, fathers being about 2½ years older than the children's mothers. The mothers in the more-intensive group did have statistically significantly more education than the mothers in the less-intensive group (the equivalent of an associates degree versus a small amount of college) but the fathers were comparable. The mothers in the more-intensive group also worked outside their home significantly more hours than their less-intensive counterparts. However, both groups only averaged a part-time job, with a broad standard deviation (suggesting a wide variability between the subjects). As a consequence of working more hours, 36% of the mothers in the more-intensive group reported using child care regularly compared to only 11% in the less-intensive group. This amount is also statistically significant. Despite the difference in child care, both sets of mothers felt they were their child's primary caregiver.

Three other variables showed statistically significant differences between the groups. More families in the less-intensive group had two parents living at home when the study first began than in the more-intensive group. Considering the theoretical foundations of this study, this variable will be carefully scrutinized in the subsequent analysis. The less-intensive group also had more males. On variables that may show a gender bias, this aspect will be considered further. The less-intensive group also reported more children than the other group. This makes the family size larger, and on the family functioning measures may make a critical difference.

Logically, most of the differences between the groups on demographic characteristics were related. Mothers with more education could be expected to work more. People who work more outside their home typically have a higher income than those who do not work outside their home (the income for the more-intensive group was indeed higher, though the differences failed to reach statistical significance). When mothers work more they have a higher need for child care. Also, when families have more children (as the less-intensive group did), child care is more expensive and families are more likely to find other alternatives.

The variables that are statistically significantly related to group membership may indeed introduce bias into the sample in spite of the randomization procedures. Because of this, analysis of the outcome measures will use covariance methods if they are appropriate. This method (which is explained in more detail later in this report) will adjust for any differences that existed following the random assignment. The results of the demographic characteristics by group is presented in Table 4.3.

Intervention Programs

At the time this research was initiated, the early intervention program of the Jordan School District was mandated to provide services to all children with disabilities, ages 3 to 5 years, who resided within district boundaries. The majority of these children were served in two schools that also served as elementary schools for children without disabilities. Other service options were possible (home services, self-contained school placement, services in a child care center) according to the needs of the child. Classrooms within the two most populous schools within the district were selected to participate in the research. Each school had children in both the less and more intensive programs.

To determine whether program intensity was related to outcome, it was critical that other factors be held as constant as possible. At each school, teachers had one morning and one afternoon session. Two teachers were involved (one teacher at each school), and each taught one less- and one more-intensive class. At one school, the less intensive class was a morning class, at the other, an afternoon class. This arrangement helped control for differences resulting from factors other than intensity.

One of the schools (i.e., one less and one more intensive condition classroom) used a reverse mainstreaming arrangement to provide services. In this school, regardless of condition, the classrooms were composed of 50% children without disabilities three days per week. This differed from the other school where children from different classrooms were brought together mostly for playground and nonacademic activities (e.g., music and art). The classroom at this school also used some peer tutors in the special education classrooms but did not mainstream to the extent of the other school.

Children in both groups were initially assessed for early intervention placement by a transdisciplinary team of professionals using norm-referenced assessment measures of general development. These assessment protocols were then forwarded to the proper teacher for eligible children. Based on this information, the teacher requested and received additional assessment information for speech/language or motor functioning. Once enrolled in the program, the children also received a criterion-referenced assessment from the teacher. All these sources of information were combined to develop each Individual Education Plan (IEP). At the IEP meeting, the parent(s) were invited to participate and help with the plan that would dictate the specific nature of intervention services for their child.

Although the majority of children in each class were in the study, some children in the less-intensive classrooms did not participate. There were approximately 15 children in each class. Classroom in both groups were was staffed by one certified teacher who had access to paraprofessional aides, communication therapists, physical and occupational therapists, and a behavior specialist. Access to aides and communication therapists varied by condition as described below. Child need (as per the IEP) dictated access to motor therapists and the behavior specialists, and this access (although not used) was equally distributed across conditions.

Teachers were free to select curricula of their choice, and classroom activities were drawn from several different curricula. However, both the teachers and communication therapists used approaches which focused on naturalistic teaching (see Haring & Innocenti, 1989). These focused on teaching the children skills that were embedded in their daily activities.

The daily organization of all the classrooms were similar. The primary curricula for the classrooms were theme-based and developmentally appropriate. The teacher established a number of activities the children selected throughout the day. These activities were either directed by the aides or the teacher. Children rotated through these activities as their interests dictated. Generally, teachers selected a number of themes that were emphasized during a school week. For example, the color green, the shape of a square, and the concept "under" were weekly themes. Large group activities, such as singing and calendar, were scheduled between other activities. Children were provided a snack each day. Children in need of more individual instruction were removed from other activities for individual or smaller (2-3 children) group instruction. Individual instructional activities were usually conducted by the teacher.

For children in both groups, regular evaluation of each child's learning objectives was required as part of the IEP process. Data on the children's objectives were collected daily, weekly, monthly, or bi-annually, depending on the objective. Specific criteria were set for each objective to guide evaluative activities.

Less intensive intervention program. This program consisted of a 3-day-per-week, 2-hour-per-day intervention service. The teacher:child ratio in the classroom was 1:5, with each classroom being staffed by a certified teacher and two paraprofessional aides. Communication therapy was provided primarily through a consultation model in which classroom staff took primary responsibility for goals and implemented activities as appropriate throughout the school day. The communication therapist was in the classroom approximately every other school day. Some children received individualized therapy from the therapist on these days. In contrast to the more-intensive intervention program, there was no group communication therapy activity conducted in the less-intensive intervention program.

More intensive intervention program. Children in this group received a 5-day-per-week, 2-hour-per-day intervention service. The teacher:child ratio in this class was enhanced from the standard program and consisted of a 1:3 ratio; one certified teacher and four paraprofessional aides per classroom. Communication therapy was delivered primarily through a consultation model, but the therapist was allowed more time to work with the teachers. The communication therapist joined each class every school day for the entire two-hour class time. During that time, the communication therapist conducted both snack and a large group communication activity in addition to the consultation and individual therapy. The communication therapist conducted snack because it provided a forum where naturalistic language activities could be modelled and taught.

Treatment Verification

This section includes data collected to verify the alternative interventions were implemented as intended. Even though the children were assigned to different groups that were designed to vary in intensity, it was important to determine how the various intervention groups actually differed. Such information was gathered based on attendance data, supervisor ratings, ratings from the teachers and parents. Additionally, on site evaluations were also conducted by people who were not associated with the intervention program and an ecobehavioral observation completed. Each of these items will be discussed below.

Attendance. Child attendance data provides one method of verifying the alternative interventions were differentially delivered and the program was worthwhile. Daily attendance records were kept by teachers and forwarded to EIRI monthly. Table 4.4 shows that subjects in both intensity groups attended regularly, each about 91% of the time.

Table 4.4

Treatment Verification Data for Jordan Intensity Study

Variable	Less Intensive			More Intensive			p Value	ES
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n		
• Days of intervention	109	(2.5)	28	178	(11.4)	25	.00	27.6
• Percent child attendance	90.0	(9.1)	28	92.6	(5.5)	25	.22	.27
• Number of days attended	98.5	(10.3)	28	165.1	(15.0)	25	.00	6.47
• Parent satisfaction♣	23.1	(4.5)	28	24.8	(2.9)	23	.11	.38
Staff working with child	3.8	(0.5)	28	3.8	(0.4)	24	1.00	.00
Ability to communicate w/staff	3.2	(0.8)	28	3.5	(0.6)	24	.17	.38
Program goals/activities for child	3.5	(0.6)	28	3.6	(0.6)	24	.35	.17
Participation in child's program	3.0	(0.9)	28	3.3	(0.8)	24	.31	.33
Services available for child	3.2	(0.9)	28	3.5	(0.6)	23	.16	.33
Child's progress	3.2	(0.9)	28	3.7	(0.6)	24	.04	.56
Child's program	3.3	(0.8)	28	3.6	(0.6)	24	.05	.38
• Teacher rating of parental' attendance	2.3	(0.8)	28	2.3	(0.8)	25	.89	.04
• Teacher rating of parental knowledge'	2.1	(0.8)	28	2.3	(0.8)	25	.52	.18
• Teacher rating of parental' satisfaction	2.1	(0.7)	28	2.2	(0.7)	25	.64	.13

♣ Satisfaction is based on the sum of seven questions that deal with various aspects of satisfaction with the center-based program. Each question is scored from 1 to 4, with 28 points possible. Higher scores indicate greater satisfaction.

' Teacher rating is based on a scale with a range of 1-3. Higher scores indicate a better rating.

$$ES = \frac{(\bar{x}\text{ more}) - (\bar{x}\text{ less})}{(SD)\text{ less}}$$

If one group had attended more regularly than the other, the research could have been significantly compromised. It is also clear from the number of days attended that the intensity of intervention was different for the two groups. On average, the children in the more intensive group attended 60% more sessions. While the length of the school day was equal, the number of days of intervention was significantly higher for the more intensive group.

Supervisor ratings of teacher and staff. At the end of the intervention, teachers and other support staffs' teaching techniques were evaluated by their supervisor (the site contact) using a structured form. Teachers and communication therapists at both schools were rated as being in the upper 25% of professionals with whom their supervisor had worked. The respective ratings, based on a 30-point scale, of the teacher and communication therapist were: 30 and 30 for one school; 24 and 28 at the other school.

Parent satisfaction. How parents felt about the various programs was also important for treatment verification. Their satisfaction was assessed through seven questions answered at the end of the year-long intervention. The seven questions were answered on a four-point Likert scale where 4 represented satisfaction and 1 represented dissatisfaction. The results of this questionnaire are presented in Table 4.4. In general, it appears most parents in both programs were satisfied. Statistically significant differences were found between the groups on two of the seven questions. Parents in the more-intensive group reported they were more satisfied with their child's progress than parents in the less-intensive group. They also felt better about the program in general. Despite the statistically significant difference, practically it should be stressed that the average reported parent satisfaction in all areas was very high. Differences only occurred within a very narrow boundary of positive satisfaction.

Teacher ratings of parents. Teachers were asked to rate each parent regarding parental support of their child, knowledge of the intervention process, understanding of their child's development, and the parent's attendance at required activities. This rating was to determine if the teachers perceived differences in the skill levels of the children's parents or the differential motivation parents exhibited toward their children's education. As shown in Table 4.4, no statistically significant differences were found between the parents in the two groups on any of these measures.

Site review. Another major source of treatment verification information came from a site review conducted during the intervention portion of the study. The purposes of this review were threefold: (a) collect information about the nature and quality of the early intervention services being delivered, (b) verify the research being conducted by EIRI was being implemented as intended, and (c) collect assessment data that may have been useful to site administrators to guide internal changes and for use when seeking technical assistance. Purposes (a) and (b) were relevant to treatment verification.

The review was conducted by a team consisting of: (a) the EIRI staff person; (b) the Jordan District site contact; (c) the Preschool Specialist for the Utah State Office of Education; and (d) a Professor of Special Education at the University of Utah. The site review was structured by the EIRI-developed Treatment Verification Guide. (A copy of the site review report and treatment verification guide can be obtained from EIRI.)

Site review findings indicated the Jordan School District Early Intervention Program was delivering appropriate, high-quality intervention services. Variables that distinguished different intensities of programs were being fully implemented. The less- and more-intensive classrooms were clearly distinct with respect to student: teacher ratios, number of days per week the intervention occurred, and frequency of speech and language therapy. According to the review, the staff at the Jordan Preschool were qualified and enthusiastic professionals whose goal was to provide quality services to preschool-aged children with disabilities. The teachers were commended on their use of developmentally appropriate classroom activities and naturalistic teaching strategies. The program was competently administered and had a well-developed procedures manual. The program-developed transition procedures for information transfer were excellent. Minor suggestions for improvement were made regarding: daily lesson plans, data collection, IEP development, assessment for program entrance, and training for aides. No threats to the validity of the research study were found.

Ecobehavioral assessment. It is possible that time differences (hours/week) may not have resulted in actual program intensity differences. For example, Carta, Sainato, and Greenwood (1988) examined preschool programs and found two programs that operated for different lengths of time but were virtually equivalent in their instructional intensity. This finding caused concern, particularly whether classroom contexts and teacher behaviors varied for classrooms of different intensity. To account for possibilities such as this, an ecobehavioral observation instrument was used.

Ecobehavioral observation assesses program variables through systematic observation. It measures moment-to-moment effects of the interaction between environment (classroom contexts), teacher behavior, and student behavior (c.f., Carta et al., 1988). The Ecobehavioral System for Complex Assessment of the Preschool Environment (ESCAPE; Carta, Greenwood, & Atwater, 1986) was used for this observational assessment.

The ESCAPE was specifically designed for use in preschool environments that serve students with disabilities. TheESCAPE assesses three major features of preschool early intervention programs: (1) the program ecology, (2) the teachers' behavior, and (3) the children's behavior. These three major categories are subdivided into 12 subcategories (see Table 4.5). All variables are recorded on a 15-second momentary time-sampling system where all categories are scored over a one-minute period. Each subcategory is examined and scored within a 15-second time period.

ESCAPE observations were conducted near the end of the first year. Each child was observed for three 10-minute samples, distributed across different days and time periods. Observations were conducted on children in all classrooms. The only child who was not observed left the more intensive classroom before observations were conducted.

Table 4.5

ESCAPE Variable and Categories Within Variables for Jordan Intensity Study

Ecology Variables

A. **Designated Activity**
The overall format on structure of the activity in which the teacher has placed the target child.

Snack
Fine Motor
Story
Play
Music/Dance/Recitation
Self-Care
Transition
Clean-up
Gross Motor
Preacademics
Class Business
Time Out
Language Programming

B. **Activity Initiator**
The person who selected the activity in which the target child was engaged.

Teacher
Child
No one

C. **Materials**
Objects with which the target child is engaged or attending to

Large Motor Equipment
Manipulatives
Bathroom
Art/Writing
Story Books
None
Instructional
Audio-Visual
Other
Pretend Play Toys
Food or Food Preparation

D. **Location**
The physical placement of the child.

On Floor
At Table
In Chair
On Equipment
In Line
Undefined

E. **Grouping**

Solitary
One teacher with one student
Small Group
Large Group

F. **Composition**
Mix of handicapped and nonhandicapped student within a group.

All handicapped
Equal
Majority nonhandicapped
Majority handicapped
None

Teacher Variables

G. **Teacher Definition**
Primary adult with whom the target child is interacting.

Teacher
Ancillary Staff
Aide
Substitute Teacher
Student Teacher
No Staff
Volunteer

H. **Teacher Behaviors**

Physical Assisting
Prompting
Gesturing/Signing
Verbal Instruction
Approval
Reading Aloud/Singing/Recitation
Disapproval
Discussion
Verbal
No Response

I. **Teacher Focus**
The direction of the behavior of the coded adult.

Target child only
Target child and others
No one
Other than target child

Student Variables

J. **Target Behaviors**
Behaviors that indicate student attention, engagement, and for participation.

Academic Work
Gross Motor Behaviors
Transition
Pretending
Singing/Reciting/Dancing
Attention
Manipulating
Self-care
None

K. **Competing Behaviors**
Behaviors which are commonly considered to be unacceptable.

Acting-out
Off-task
Self-stimulation
None

L. **Verbal Behavior**
Verbal or signed expression.

Talk to Teacher
Talk to Peer
Undirected
No Talk

To assess the reliability of the observation system, two observers recorded data concurrently and independently for 25% of the samples. Agreement between observers, calculated as the percentage of intervals in which both observers selected the same category for a particular variable, averaged 95% across variables, with a range from 86% to 100%.

Results from several key components of the ecobehavioral observation system are presented in Table 4.6. This table presents results of teacher engagement and grouping of students in the classroom. Engagement values are determined based on a child's behavior across all student behavior categories during a single interval. Appropriate engagement is hypothesized to be the primary behavior contributing to child development (Carta et al., 1988; Greenwood, 1991; Greenwood, Delquadri, & Hall, 1984; Innocenti, 1990).

Table 4.6

Percentage of Time in Categories Observed by the ESCAPE for the Jordan Intensity Study

	Less Intensive			More Intensive				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Grouping								
Small Group	24.8	26.4	28	38.6	24.7	24	.06	.52
Large Group	71.0	27.1	28	52.8	24.8	24	.02	-.67
1 Teacher w/1 Student	1.5	3.7	28	2.7	8.0	24	.51	.32
Solitary	2.7	5.0	28	4.1	6.0	24	.36	.28
• Engagement								
Appropriate Engagement	42.2	19.6	28	43.2	18.6	24	.86	.05
Appropriate, Not Engaged	30.8	17.3	28	29.3	16.1	24	.76	-.09
Appropriate Engagement w/Other Behavior	24.7	15.8	28	23.9	11.2	24	.84	-.05
Appropriate, Not Engaged w/Other Behavior	2.2	3.8	28	2.9	4.8	24	.54	.18

$$ES = \frac{(\bar{x}\text{ more}) - (\bar{x}\text{ less})}{(SD)\text{ less}}$$

Teachers, overall, responded similarly to children in both groups. Most importantly, percentages of time spent in appropriate engagement were similar between the groups. These results suggest that, even though the amount of intervention time varied between the groups, the percentage of available time in both groups was spent in very similar activities.

The major difference between the two groups was that the children in the more intensive classroom engaged in these activities for more hours per week than the children in the less intensive group. Also, subjects in the more intensive group spent significantly more time in small groups, while the less intensive children were in large groups more often. The intensity differences were designed to provide a higher teacher:child ratio for the time that subjects were engaged; the data in the grouping category suggests that the objective was achieved.

It appears the intervention was administered as planned. Data from the supervisors, teachers and parents suggest they were each happy with the services that were delivered. Attendance verifies the caliber of the program and its success in meeting the needs of the population it was designed to serve. Further evidence from the site review confirmed the equity of the treatment between the two groups. Verifiable data from the ecological assessment observation corroborated the site review and provided further evidence that the two groups were treated about the same.

Contextual Variables

Despite the care taken to administer two intensities of intervention to two similar groups, several factors other than the intervention intensities could be responsible for subsequent differences between the groups in children's development and family functioning. The random nature of assignment to groups suggests both similarity of the groups and significant differences by random chance. It was impractical and unreasonable to control for all the variables that impact child development and family functioning, so a concerted effort was made to identify these variables and monitor them throughout the study.

Information about variables such as child health, various family events, and what happens at school were gathered each year. If the two groups were equivalent to each other on each of these contextual variables throughout the course of the study, the differences in their developmental outcomes may be attributed to the intervention with increased confidence. However, to the degree the groups are dissimilar, significant differences in subsequent outcome measures may be attributed to the variation in contextual variables, or the separate interventions, or a combination of both.

A portion of the information needed to identify the contextual variables was gathered though a demographic survey parents completed each year. A number of these variables were reported in Table 4.3 in an analysis of initial differences between the groups. Other measures that were outside the control of the study or family included the family's resources (measured by the Family Resources Scale) and the recent major life events the family has experienced (measured with the Family Inventory of Life Events through reassessment #1 and Holmes-Rahe Major Life Events for reassessments three through six). These measures are described more completely in a subsequent section.

Because children's health plays a role in their development and the development of their families, mothers were asked to compare their child's health to the health of their peers. Outside services--or those services administered independently of the school district or intervention--were also monitored annually. The initial teacher evaluations of the parents were also considered to be a contextual variable.

Table 4.7 displays these variables for each reassessment through #6. The *p*-value and effect sizes are also shown, indicating the few significant, but consistent, differences.

Initially, and through each reassessment, the mothers of children in the more intensive program reported a statistically significant higher degree of education. Although there is not much variation from year-to-year, the effect sizes range from slightly above a half a standard deviation to almost one standard deviation. The

Table 4.7

Comparison of Contextual Variables for Less and More Intensive Groups in the Jordan Intensity Study

	More Intensive			Less Intensive				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES^
Initial Assessment								
Family Measures								
Family Resources (FRS)♦	116.1	(15.3)	28	122.8	(20.2)	25	.18	.44
Family Life Events (FILE)***	9.8	(5.1)	28	11.4	(7.9)	25	.40	-.31
Reassessment #1								
General Health of Child♦	2.0	(.6)	28	2.0	(.6)	23	.64	0
Demographic Variables								
Mothers years of education	12.7	(1.9)	28	14.2	(1.9)	25	.01	.79
%Mothers employed outside the home	28.6		28	45.8		24	.20	.43
Hours per week mother at work	10.5	(16.4)	28	17.7	(20.9)	25	.16	.44
Father's years of education	13.9	(1.8)	28	14.3	(2.5)	24	.55	.22
% Fathers employed as tech/managerial	39.3		28	52.2		23	.36	.30
Hours per week father at work	42.3	(17.9)	28	39.3	(15.2)	22	.54	.17
Total household income	$27,624.5	($9,185.0)	28	$32,579.5	($17,992.3)	25	.21	.54
% living with mother and father	100.0		28	87.5		24	.05	.82
# of siblings	3.3	(2.1)	28	1.9	(1.5)	25	.01	.67
# of siblings w/disabilities	.5	(.7)	28	.4	(.9)	24	.79	.14
Family Measures								
Family Resources (FRS)♦	123.0	(15.4)	28	125.3	(17.1)	25	.61	.15
Family Life Events (FILE)***	9.6	(5.5)	28	8.9	(6.5)	25	.68	.13
Teacher Evaluations								
Teacher rating of parent attendance	2.3	(.8)	28	2.3	(.8)	25	.89	0
Teacher rating of parent knowledge	2.1	(.8)	28	2.3	(.7)	25	.52	.25
Teacher rating of parent support	2.1	(.7)	28	2.2	(.7)	25	.64	.14
Additional Services•								
% receiving speech therapy**	10.7		28	16.0		25	.57	.22
% receiving PT/OT**	14.3		28	4.0		25	.20	.48

♦ Based on parent rating of the child's health: 1 = worse than peers, 2 = same as peers, 3 = better than peers. (continued)

• Data are based on parent report, obtained at reassessment, of services the child received outside of school during the preceding year

•• Statistical analyses are based on χ^2 analysis where those receiving services were scored "1" and those not receiving services "0."

••• The Holmes and Rahe and the FILE are based on raw scores where lower scores are considered better.

♦ Analyses for the FRS is based on raw scores where higher scores indicate greater resources.

^ $$ES = \frac{(\bar{x}\text{ more}) - (\bar{x}\text{ less})}{(SD)\text{ less}}$$

Table 4.7 (continued)

Comparison of Contextual Variables for Less and More Intensive Groups in the Jordan Intensity Study

	More Intensive			Less Intensive				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES^
Reassessment #2								
General Health of Child♦	2.1	(.6)	28	2.1	(.6)	25	.93	0
Demographic Variables								
Mothers years of education	12.8	(1.9)	28	14.1	(1.9)	25	.01	.68
% mothers employed outside home	39.3		28	52.0		25	.35	.30
Hours per week mother at work	9.9	(16.5)	25	18.2	(21.9)	22	.15	.50
Fathers years of education	14.0	(1.7)	26	14.6	(2.4)	21	.31	.35
% fathers employed at tech/managerial	28.6		28	63.6		22	.01	.84
Hours per week father at work	38.6	(12.9)	25	39.7	(10.9)	19	.76	.09
Total household income	$30,462.5	($13,096.5)	27	$33,749.5	($18,091.6)	24	.46	.25
% living with father and mother	100		28	82.6		23	.02	.99
# of siblings with disabilities	.7	(.8)	28	.5	(.9)	25	.40	.24
Family Measures								
Family Resources (FRS)♠	122.0	(12.8)	28	119.1	(20.7)	25	.53	.23
Additional Services*								
% receiving speech therapy**	25.0		28	16.0		25	.42	.27
% receiving PT/OT**	14.3		28	4.0		25	.20	.48
Reassessment #3♦								
General Health of Chid	2.1	(.6)	27	2.1	(.5)	25	.97	0
Demographic Variables								
Mothers years of education	12.8	(1.9)	26	13.9	(2.5)	24	.09	.58
% mothers employed outside the home	61.5		26	56.5		23	.72	.12
Fathers years of education	14.2	(1.8)	24	14.8	(1.9)	20	.26	.33
% fathers employed as tech/managerial	30.4		23	70.0		20	.01	.94
Total household income	$35,073.6	($14,706.6)	27	$38,395.4	($24,547.7)	24	.56	.23
% living with father and mother	96.2		26	90.5		21	.43	.34
# of siblings	3.3	(2.0)	27	2.1	(1.5)	25	.02	.60
Family Measures								
Family Resources (FRS)♠	127.1	(14.7)	28	124.1	(16.0)	25	.49	-.20
Holmes and Rahe Total***	150.9	(177.8)	28	183.1	(119.0)	25	.45	-.18
Holmes and Rahe Primary*** Negative Impact Score	39.4	(58.0)	28	44.4	(60.2)	25	.76	-.09
Additional Services*								
% receiving speech therapy**	7.1		28	8.0		25	.91	.06
% receiving PT/OT**	14.3		28	12.0		25	.81	.08

(continued)

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Table 4.7 (continued)

Comparison of Contextual Variables for Less and More Intensive Groups in the Jordan Intensity Study

	More Intensive			Less Intensive				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES^
Reassessment #4								
General Health of Child♦	2.2	(.7)	26	2.1	(.5)	25	.68	.14
Demographic Variables								
Mothers years of education	12.7	(1.7)	27	14.2	(2.0)	25	.01	.88
% mothers employed outside the home	92.6		27	96.0		25	.60	.18
Fathers years of education	14.0	(2.0)	28	12.5	(5.4)	23	.18	.75
% fathers employed as tech./managerial	28.6		28	43.5		23	.27	.37
Total household income	$34,231.6	($17,290.3)	28	$38,679.5	($22,224.7)	25	.42	.26
% living with father and mother	96.4		28	87.0		23	.21	.51
# of siblings	3.3	(2.1)	28	1.9	(1.3)	25	.01	.67
# of siblings w/disabilities	1.7	(.9)	28	1.4	(.7)	25	.12	.33
Family Measures								
Family Resources (FRS)♠	125.0	(12.0)	28	123.8	(16.8)	25	.78	.10
Holmes and Rahe Total***	168.6	(156.2)	28	145.1	(78.8)	24	.51	.15
Holmes and Rahe Primary*** Negative Impact Score	33.8	(63.2)	28	33.4	(38.6)	24	.98	.01
Additional Services*								
% receiving speech therapy**	7.1		28	4.0		25	.62	.17
% receiving PT/OT**	10.7		28	4.0		25	.36	.34
Reassessment #6								
General Health of Child♦	2.2	(.5)	28	2.0	(.5)	25	.32	.40
Demographic Variables								
Mothers years of education	12.6	(1.7)	27	14.0	(2.1)	25	.01	.82
% mothers employed outside the home	67.9		28	64.0		25	.77	.10
Fathers years of education	14.2	(2.1)	27	14.4	(2.5)	21	.71	.10
% fathers employed as tech./managerial	28.6		28	54.2		24	.06	.62
Total household income	$33,749.5	($16,262.0)	28	$35,219.5	($18,530.5)	25	.76	.09
% living with mother and father	89.3		28	76.0		25	.20	.47
# of siblings	3.4	(2.0)	28	2.3	(1.3)	25	.02	.55
Family measures								
Family Resources (FRS)♠	123.3	(10.4)	28	121.1	(18.0)	25	.59	-.21
Holmes and Rahe Total***	135.9	(95.2)	28	184.9	(116.6)	25	.10	-.51
Holmes and Rahe Primary*** Negative Impacts Score	30.1	(51.9)	28	41.7	(56.6)	25	.44	-.22
Additional Services*								
% receiving speech therapy**	14.3		28	8.0		25	.47	.25
% receiving PT/OT**	10.7		28	0		25	.09	.68

(continued)

(see notes on previous page)

Table 4.7 (continued)

Comparison of Contextual Variables for Less and More Intensive Groups in the Jordan Intensity Study

Variable	More Intensive			Less Intensive			P Value	ES^
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n		
Reassessment #6								
General Health of Child♦	2.2	(.5)	27	2.0	(.6)	24	.23	.40
Demographic Variables								
Mothers years of education	12.7	(1.8)	26	14.4	(1.9)	24	.00	.94
% mothers employed outside the home	53.8		26	62.5		24	.54	.20
Fathers years of education	14.2	(1.8)	23	14.6	(2.4)	21	.54	.22
% fathers employed as tech./managerial	30.4		23	61.9		21	.04	.74
Total household income	$37,684.7	($21,079.2)	27	$41,478.7	($20,602.7)	24	.52	.18
% living with father and mother	81.5		27	83.3		24	.86	.05
# of siblings	2.9	(2.3)	27	1.7	(1.4)	24	.03	.52
Family Measures								
Family Resources (FRS)♠	124.4	(14.6)	27	122.0	(15.9)	24	.58	-.16
Holmes and Rahe Total***	156.6	(148.0)	27	186.8	(133.0)	24	.45	-.20
Homes and Rahe Primary* Negative Impact Score**	39.5	(46.4)	27	44.0	(57.9)	24	.76	-.10
Additional Services*								
% receiving speech therapy**	0		28	4.0		25	.29	.39
% receiving PT/OT**	7.1	28	8.0		25	.91	.06	

actual differences do not change much from the initial assessment where the less intensive group reported graduating from high school and the more intensive group reported the equivalent of an associates degree (2 years of college, on average).

The percentage of mothers employed outside their home does not differ significantly between the groups at any single reassessment although the numbers change from year to year. Initially, and for the first two reassessments, the majority of the mothers did not choose outside employment. At reassessment #3, however, almost 60% did have employment outside their home. At reassessment #4, 94% of the mothers reported working outside the home. The number of hours they worked was not reported that year. By reassessment #5 and for reassessment #6 the percentage returned to an amount comparable to the other years (66% and 58% overall). The group reporting the largest percentage of mothers employed outside their home changes several times throughout the course of the study, but they each reported a comparable amount of increase or decrease through the years.

Beginning at reassessment #2, a statistically significant greater number of families in the more-intensive group reported their fathers working in technical/managerial or higher positions than families in the less-intensive group. Initially and through each reassessment, approximately 30% of the fathers in the less-intensive group worked at the higher positions and maintained their amount of education. Fathers in the more-intensive group showed more variability however and between 50 and 70% of them were employed in technical/managerial positions--depending on the year. The number of years spent in school remained fairly constant, at about the same amount as the less-intensive group, approximately 14 years.

Family constellation did not change dramatically through the years. Most families reported having one sibling to the child with disabilities throughout the years. A number of families did report two siblings, enough to make the mean number of children above 2.5 most years. As mentioned previously, there was a statistically significant difference between the groups where the families in the less-intensive group reported having a mean of 1.4 more siblings over the years ($\bar{x}$ = 1.37) than the more-intensive group. The average effect size of this difference was 59% of one standard deviation. The number of those siblings who had disabilities did not differ between the groups at any reassessment. The percentage of children living in two-parent families changed somewhat over the years, but still remained above 80%. Until reassessment #3 all of the children in the less-intensive group were living in two-parent families while only between 80 and 90% of those in the more-intensive intervention were. This difference was statistically significant ($\chi^2(1) \approx 4.0$, $p < .05$, ES = .91). Beginning at reassessment #3 the groups converged until, at reassessment #6, 82% of the children in both groups (±1%) were living in a two-parent household.

The number of resources available to the families (as measured by the FRS) in the different groups does not vary greatly between groups or between years. Dunst, Jenkins, and Trivette (1984) did not report standardization statistics for this measure, but percentiles were computed based on all the initial assessments across the longitudinal studies at EIRI. Using the EIRI sample, the subjects at the Jordan site scored between the 51st and 67th percentile across all reassessments. Based on the results of this measure, it appears the groups did not differ in their perceived needs at any reassessment. Furthermore, in comparison to the other sites in this set of studies, these families did not perceive any great need in resources as a group.

The results of the FILE were very similar to the FRS. Groups did not differ statistically significantly from one another nor did they change much from one year to the next. However, the FILE was only administered at two assessment periods, and between those two times the more-intensive group reported, on average, fewer major life events.

Beginning at reassessment #3, major life events were measured by the Major Life Events scale (Holmes & Rahe, 1967). This scale includes 43 life events that can contribute to stress. It has positive, negative, and normal items that occur in family life. The items are rank ordered with more stressful life events receiving a higher score than less stressful life events. High scores translate to more life events that negatively impact people and their families. The authors report using both a scale total score and a negative events score. Normative data is not reported. Groups did not report statistically significant differences at any given year for the total stress score, although the high-intensity group reported more stressful life events 3 out of 4 years. Effect sizes were generally around .18 except for reassessment #5 when it reached ½ a standard deviation. The groups did not differ by more than twelve points for any reassessment on the negative impact score. There was also little variability between years, each group reporting approximately the same score at each reassessment.

Additional services obtained by the families that were not included with services offered by the school district could also account for differences in developmental outcome. Parents were asked each year if their children had received additional services the previous year. The only statistically significant difference occurred at reassessment #5 when none of the children in the more-intensive group received physical and occupational therapy (PT/OT) and almost 11% of the children in the less-intensive group did. The percentage of children receiving these services outside the school settings is very consistent. Speech therapy is more variable, but shows no significant differences between the groups. Neither variable changes much from year to year. Over 84% of the children in the study at any particular reassessment reported not having any additional outside therapies.

Parents' knowledge, support and commitment to their children's education could also influence development. These were measured at reassessment #1, directly following the intervention. Teachers rated the parents of children in their classrooms in comparison to other parents on a scale of one to three. As Table 4.4 indicates, there were no statistically significant differences by group. The rating for each of the scales was slightly above "2," (teachers perceived the parents of the children in their classes as "average" when compared to other parents).

The children's general health was rated each year in terms of the parents' perception of how their children compared to their peers' health. They responded to whether their children were more healthy, about the same, or less healthy than their peers. Across groups and across reassessments parents responded, as a group, that their children's health was about the same as their peers.

Over the years, several contextual variables were measured and included in the analysis of differences between the groups. There have been few, but consistent, differences between the groups throughout the study. Families in the more-intensive group consistently reported more education for their mothers and higher occupational status for their fathers. The families who were in the less-intensive group reported a greater number of children. Through reassessment #3, the less-intensive group also had more families who reported having two parents living in their homes.

Cost of Alternative Interventions

The cost analysis for this study was conducted during the 1988-89 school year, the year of the more- or less-intensive preschool classrooms. Costs are based on those classrooms (two less intensive, two more intensive) involved in the study. Cost estimates are based on a class of 15 students. Even though the number of subjects for the study was not 15 per class in all classes, classes were designed for 15 students. Cost data were obtained using the ingredients approach, a systematic, well-tested procedure for identifying all of the social costs for implementing alternative programs. It includes costs, such as shared resources, that are often omitted from cost analyses. As shown in Table 4.8, each alternative used direct service and administrative personnel, occupancy, equipment, transportation, and materials and supplies in varying amounts according to the intensity of the program. The cost estimates in Table 4.8 are reported in 1990 dollars.

Table 4.8

Cost Per Child for Jordan Intensity Study

Resources	Less Intensive	More Intensive
Agency Resources		
Direct Services	$1,709	$3,570
Administration		
Preschool	623	623
District	35	59
Occupancy	294	502
Equipment	71	119
Transportation		
Children	405	676
Staff	14	22
Materials/Supplies	52	87
TOTAL	**$3,203**	**$5,658**

Direct service personnel included a teacher, a speech and language therapist, a physical therapist, an occupational therapist, and two aides in each class. Preschool administrative personnel included salaries and benefits for the program director and a secretary. District administration include the school principal, the special education director, and other necessary district administration, as well as the bus drivers and bus aides. Space maintenance, utilities and insurance costs were included under occupancy. Equipment encompassed all instructional materials, office furniture, and equipment, and materials and supplies.

Child transportation included fuel, maintenance, depreciation, and annualized cost of the vehicle seats/restraints. Personnel salaries were converted to full-time equivalent (FTE) amounts.

The use of FTE converts time spent on the project to a full-time base. It allows comparisons between personnel by converting their time to a common metric. The same direct-services staff conducted the 5- and 3-day intervention, but two additional aides were employed for the more-intensive intervention. Of course, direct-service staff reported devoting more of their total FTE to the five-day program. The salaries and benefits for direct service personnel were determined according to FTE devoted to each program alternative.

Preschool administrative personnel, interestingly reported spending approximately the same proportion of FTE on administrative duties for both programs. The administrative cost of operating the program on the district level was calculated according to the district's indirect rate for operating federal programs (1.1%). Occupancy charges, including space, maintenance, utilities, and insurance costs were based on the school district leasing cost of $6 per square foot per year. One thousand thirteen square feet were allocated for the three-day program, and 1,688 square feet for the five-day program. Annual equipment cost was determined by taking inventory of all instructional materials, office furniture, and equipment. Market replacement values were then applied to each item, costs were annualized to account for interest and depreciation and were prorated according to usage by each alternative. Staff travel was based on actual mileage (at $.25 per mile) for the teachers' and therapists' travel related to the respective intervention programs.

The cost of materials and supplies was assessed based on actual usage of these items by each alternative.

Collection of Outcome Data

The data for this study were collected to assess the effects of intervention not only on children, but also their families. As noted earlier, initial assessment data and data from Reassessments #1 through #6 have been collected. Table 4.9 shows the instruments used to obtain data on children and their families at each time period. A brief description of each of these instruments is presented in Table 4.10.

Table 4.9

Schedule of Administration and Tests Administered for Jordan Intensity Study

	Pretest	Re. #1	Re. #2	Re. #3	Re. #4	Re. #5	Re. #6
CHILD MEASURES							
Battelle Developmental Inventory	X	X	X				
Woodcock-Johnson Tests of Achievement				X	X	X	X
Joseph Preschool/Primary Self-Concept		X	X				
Perceived Competence/Social Acceptance				X	X	X	X
Scales of Independent Behavior				X	X	X	X
Child Health		X	X	X	X	X	X
Social Skills Rating System				X	X	X	X
Developmental SPECS		X	X	X	X	X	
Cooper Farran Behavior Rating Scale		X	X				
FAMILY MEASURES							
Outcomes:							
Parent Stress Index	X	X	X	X			
Parent Stress Index Short Form					X	X	X
Parent Self-Awareness Scale				X	X	X	X
Family Adaptation and Cohesion Evaluation Scales	X	X	X				
Comprehensive Evaluation of Family Functioning				X			
Family Support Scale	X	X	X	X	X	X	X
Child Vulnerability Scale						X	
Parent Protection Scale						X	
Teacher Rating of Parent Participation				X	X	X	X
Contextual Variables:							
Family Resource Scale	X	X	X	X	X	X	X
Family Inventory of Life Events and Changes	X	X					
Holmes & Rahe Major Life Events				X	X	X	X
Parent Involvement in Child Care Inv.				X			

Table 4.10

Description of Tests Administered for Jordan Intensity Study

MEASURES	DESCRIPTION
Battelle Developmental Inventory (BDI) (Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984)	A norm-referenced test of developmental functioning completed through child administration and parent interview. Assesses personal/social, adaptive, motor, communication, and cognitive skills, and provides a total score.
Woodcock-Johnson Tests of Achievement (Woodcock & Johnson, 1989)	A norm-referenced test of achievement. The test consists of nine aspects of scholastic achievement: Letter-word Identification, Passage Comprehension, Calculation, Applied Problems, Dictation, Writing Samples, Science, Social Studies, and Humanities.
Scales of Independent Behavior (SIB) (Bruininks, Woodcock, Weatherman, & Hill, 1985)	The SIB is a norm-referenced test which assesses the functional independence and adaptive behavior of a child. The test is organized into four subdomains: motor skills, social and communication skills, personal living skills, and community living skills.
Joseph Preschool and Primary Self-Concept Screening Test (JSI) (Joseph, 1979)	Assesses the self-concept of children ages 3.6 to 9.11 years via responses to line drawings. It provides a global self-concept score.
Developmental SPECS (System to Plan Early Childhood Services) (Bagnato & Neisworth, 1990)	Assesses adult perceptions (judgment-based assessment) of child capabilities on 20 developmental dimensions that encompass six domains: communication, sensorimotor, physical, self-regulation, cognition, and self-social.
Social Skills Rating Scale (SSRS) (Gresham & Elliott, 1990)	A norm-referenced measure of child social skills and school success. Ratings are obtained from the child's parent and teacher.
Perceived Competence and Social Acceptance (Harter & Pikes, 1983)	A pictorial scale of perceived competence and social acceptance for young children that assesses four domains: cognitive competence, physical competence, peer acceptance, and maternal acceptance.
Cooper Farran Behavioral Rating Scales (Cooper & Farran, 1988)	Assesses the classroom behavior of students as it relates to interpersonal skills and work-related skills. Teacher provides information on student's performance on each of 39 dimensions.
FAMILY MEASURES	
Parent Stress Index (PSI) PSI Short Form (Abidin, 1986)	Assesses parent perceptions of stress on the parent-child system. The two main domains are child-related factors and parent factors.
Family Support Scale (FSS) (Dunst, Jenkins, & Trivette, 1984)	Assesses the availability of sources of support as well as the degree to which different sources of support provided are perceived as helpful to families rearing young children.
Family Resource Scale (FRS) (Dunst & Leet, 1985)	Assesses the extent to which different types of resources are perceived as adequate in households with young children. Factors include: General Resources, Time Availability, Physical Resources, and External Support.
Family Inventory of Life Events and Changes (FILE) (McCubbin, Patterson, & Wilson, 1983)	Assesses life events and changes experienced by a family unit during the past 12 months. The specific areas of potential strain covered by the scale include: intra-family, marital, pregnancy and childbearing, finance and business, work-family transitions, illness and family "care," losses, transitions "in and out," and legal.
Family Adaptation and Cohesion Evaluation Scale - III (FACES) (Olson, Portner, & Lavee, 1985)	Provides a general picture of family functioning by assessing the family's level of adaptability and cohesion. Family cohesion assesses degree of separation or connection of family members to the family. Adaptability assesses the extent to which the family system is flexible and able to change in various situations. The scale also has a perceived as well as ideal form that provides an indication of the extent to which current family functioning is consistent with the family's expectations for ideal family functioning.

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Table 4.10 (continued)

Description of Tests Administered for Jordan Intensity Study

MEASURES	DESCRIPTION
Comprehensive Evaluation of Family Functioning (CEFF) (McLinden, 1989)	Assesses areas in which a family having a child with special needs may be affected. Areas assessed are: time demands, acceptance, coping, social relationships, financial demands, well-being, and sibling relationships.
Parent Self-Awareness Scale (PSAS) (Snyder, Weildreyer, Dunst, & Cooper, 1985)	Assesses parent perceptions of empowerment in the areas of decision making, obtaining information, and in interactions with self and others.
Holmes & Rahe Major Life Events (Holmes & Rahe, 1967)	Assesses parent stress resulting from major life events that occurred within the past year.
Parent Protection Scale (PPS)	A rating scale of parental protective behaviors toward children age 2-10 years.
Child Vulnerability Scale (CVS) (Forsyth)	Assesses the degree to which parents worry about their children's health.

Recruitment, training, and monitoring of diagnosticians. Diagnosticians who were recruited for the study successfully completed certification procedures required for the Battelle Developmental Inventory (BDI) at the initial assessment, reassessment #1 and reassessment #2, and for the Woodcock Johnson--Revised Achievement Scale (WJ-R) and Scales of Independent Behavior (SIB) at reassessments #3 through #6. Testers were recruited through the Early Intervention Research Institute at Utah State University. Only testers who were "blind" to the group membership of children participating in the study were recruited. All diagnosticians had a minimum of a Bachelor's Degree and experience working with young children who have disabilities. Certification included an extensive in-service training on the BDI, WJ-R, and SIB administration and scoring. Prior to collecting data for the study, each examiner was required to administer a minimum of three assessments, two of which were observed for quality control. Further, each examiner was "shadow scored" for reliability at least once during each test period. For Reassessment #1, an average of 9% of all tests were "shadow scored" (watched and scored by another certified tester) for interrater reliability. Average agreement was 90% and ranged from 77 to 100%. Eleven percent of all tests were shadow scored for Reassessment #2, and average agreement was 91% with a range of 84 to 97%. Reassessment #3 resulted in average agreement of 96% for the Woodcock-Johnson, with the range from 87% to 100%, and averaged 98% for the SIB, with a range of 94% to 100%. Reassessment #4 reliability averaged 99% with 9% of all tests shadow scored. Thirteen percent of the W-J and SIBs were shadow scored at reassessment #5 with mean reliability of 99%. At reassessment #6, six of the 52 (11%) WJ-Rs were shadow scored for a mean reliability of 99% (ranging from 96% to 100%). Agreement on the SIB averaged 99%.

For reassessment #1, the Joseph Self-Concept Inventory was administered by a graduate student in the School Psychology Program at the University of Utah. The site coordinator provided training on the Joseph prior to the first administration. Children were administered the Joseph during their school day. Reassessment #2 Josephs and reassessments #3 through #6 Perceived Competence and Social Acceptance measures were administered by the same diagnosticians who gave the BDI and WJ-R, respectively. Each examiner received training in the Self-Concept measure from the site coordinator and the assessment coordinator prior to administration.

Initial assessment. Initial assessment data were collected at the beginning of the first academic year. Parents and subjects completed a core pretest battery of assessment measures that were common across sites. This battery included the Battelle Developmental Inventory (BDI), Parenting Stress Index (PSI), Family Support Scale (FSS), Family Resource Scale (FRS), Family Inventory of Life Events and Changes (FILE), and the Family Adaptability and Cohesion Scales (FACES III).

Family functioning has been an overlooked variable in early intervention research (Casto & Mastropieri, 1986; Dunst, 1986). Although theoretically it is assumed that early intervention will affect families and families will affect their children (Bronfenbrenner, 1979), the specific areas that may be impacted are unknown and may vary depending on the type of intervention. A battery of family functioning measures was used in this study to help elucidate areas of functioning that may be affected by different intensities of intervention.

Parents also provided demographic information at the initial assessment. More information on these measures can be found on Table 4.10 and in the Final Report of the Longitudinal Studies of the Effects of Costs of Early Intervention for Handicapped Children (White, 1991).

Reassessment #1. At the end of the first academic year all 53 children who participated in the intervention were assessed using the same measures as the initial assessment. Additional measures included the Perceptions of Developmental Status (PODS), the predecessor to the Developmental SPECS, the parent satisfaction with testing and services, and a measure of child health. The parent satisfaction measures were used for treatment verification and to refine the testing procedures for subsequent reassessments. The child health measure was a contextual variable in which children were rated by their parents as being less healthy, about the same, or more healthy than their peers.

Additional measures included the Joseph Preschool/Primary Self-Concept Inventory and the Cooper Farran Behavior Rating Scale (CFBRS). The Joseph provided a global assessment of self concept via responses to line drawings for children ages three to nine years. The CFBRS assesses the interpersonal and work related skills of students within the classroom environment. This measure is completed by the student's teacher and includes information on the students performance on each of 39 dimensions.

Reassessment #2. The second reassessment was completed in June, 1990. The same 53 children and their families participated. The measures were the same as reassessment #1, except the FILE was discontinued.

Reassessment #3. A third reassessment was completed with all 53 children by the end of June 1991. Several children had reached the upper age limits of the BDI so the WJ-R and SIB were introduced to replace the BDI. The WJ-R provided a more age appropriate assessment of developmental competencies, particularly in the area of scholastic achievement.

The Cooper-Farran Behavior Rating Scale, Joseph Preschool/Primary Self Concept Inventory, and the Family Adaptation and Cohesion Evaluation Scales were not used during this assessment. Replacing these measures were: Social Skills Rating System (SSRS), Perceived Competence and Social Acceptance (PCSA), Parent Involvement in Childcare Inventory (PICI), Comprehensive Evaluation of Family Functioning (CEFF), Parent Self Awareness Scale (PSAS), and the Homes & Rahe Major Life Events (MLE). These measures were used in assessing the children's use of appropriate social skills as perceived by their teachers and parents (SSRS), the children's functional independence and adaptive behavior (SIB), their perceptions of their own cognitive and physical competence as well as peer and maternal acceptance (PCSA), the extent to which parents were involved in childcare (PICI), time, financial concerns, coping and other demands placed on families with special needs children (CEFF), parents' perceptions of empowerment (PSAS), and the occurrence of major life events (MLE) during the past year such as the death of a loved one, automobile accidents, hospitalizations, etc.

Reassessment #4. The procedures for reassessment #4 remained the same and all 53 children were evaluated by the end of June 1992. No new measures were added at this assessment but the Parent Stress Index was exchanged for the Parent Stress Index Short Form. The PICI was dropped at this time.

Reassessment #5. Reassessment #5 was completed in July 1993 for all 53 families using the same measures used at reassessment #4. In addition, the Child Vulnerability Scale (CVS) and the Parent Protection Scale (PPS) were administered during this year only. The CVS assessed the degree to which parents worry about their children's health. The PPS was used as a rating of parent protective behaviors toward the child.

Reassessment #6. Reassessment #6 was completed in June 1994 using the measures that were used at reassessment #4. At this reassessment, the Developmental SPECS was not administered. One family decided not to continue in the study. They reported their child had been assessed excessively through various organizations (i.e. the school system, hospitals) and they did not want to subject him to any further testing. The remaining 52 families were evaluated similarly to previous reassessments. There were no new measures at this reassessment.

Results and Discussion

Fifty-three children participated in two different intensities of intervention for one year. Data were collected annually for six years following those interventions. The results of Reassessment #1 represented an immediate test of the effects for the different intensities provided to the children in the study. Reassessments #2 through #6 were a follow-up to the intensity question and provided information regarding whether differences between groups appeared following the intervention and whether initial differences were maintained through time. First, the comparability of groups at the initial assessment will be presented. The results of child functioning at each reassessment follow and then the results of each reassessment's family measures are presented. Finally, educational placement will be discussed.

Comparability of Groups on Initial Assessment Measures

The comparability of groups on demographic and contextual characteristics were presented in Tables 4.3 and 4.7. Statistically significant differences ($\underline{p} < .10$) were observed between the groups on 6 of the 20 initial assessment variables. Other measures taken at the initial assessment generally failed to show statistically significant differences between the groups ($p < .10$). Subjects were statistically comparable on all BDI domains and the BDI total score. The children were also close to the same chronological age. Families reported comparable amounts of stress, support, and adaptability. The only statistically significant difference between groups occurred on the cohesion subscale of the FACES (see Table 4.11). Families in the more-intensive group generally perceived their family to be more cohesive.

The average effect size across all initial child and family measures was .20 (averaged across Tables 4.3, 4.7, and 4.11). The initial assessment confirms the similarity between the groups on identifiable characteristics on both child and family functioning measures.

Table 4.11

Comparability of Groups on Pretest Measures for Jordan Intensity Site

	Less Intensive				More Intensive					
Variable	x	(SD)	%ile	n	x	(SD)	%ile	n	p Value	ES[&]
• Age in months at pretest	50.0	(6.8)		28	50.3	(6.3)		25	.88	.04
• Battelle Developmental* Inventory (BDI)										
Personal Social	98.4	(22.2)		28	97.2	(19.6)		25	.84	-.05
Adaptive Behavior	65.1	(14.9)		28	68.1	(10.0)		25	.40	.20
Motor	92.6	(18.6)		28	95.8	(14.1)		25	.49	.17
Communication	48.3	(12.4)		28	47.4	(9.4)		25	.78	-.07
Cognitive	39.6	(10.5)		28	39.9	(10.1)		25	.91	.03
TOTAL	344.0	(64.5)		28	348.4	(48.1)		25	.78	.07
• Parenting Stress Index (PSI)**										
Total (range 101 to 504)	237.5	(29.9)	70	28	233.7	(55.4)	66	25	.75	.13
Child Related (range 54 to 270)	112.5	(17.9)	83	28	114.6	(30.3)	86	25	.78	-.12
Other Related (range 101 to 504)	125.0	(19.1)	58	28	119.1	(30.1)	47	25	.39	.31
• Family Support Scale (FSS)^ Total Score (range 0 to 4)	2.1	(.7)		28	2.1	(.7)		25	.99	.00
• Family Adaptability and Cohesion Evaluation Scales III (FACES III)										
Cohesion	38.9	(4.4)		27	42.1	(5.1)		25	.02	.73
Adaptability	24.3	(4.8)		27	26.6	(5.0)		25	.11	.48

* Statistical analysis for BDI scores was conducted using raw scores for each of the scales.

^ Analyses for the FSS are based on raw scores indicating number of supports or resources reported as being available. Higher scores are considered better. The score presented represents the sum of perceived support divided by the number of reported sources.

** The PSI is based on raw scores where lower scores are considered better.

[&] Effect Size (ES) is defined here as the difference between the groups (More Intensive minus Less Intensive) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation of the Less Intensive Group (see Glass, 1976; Tallmadge, 1977 and Cohen, 1977 for a more general discussion of the concept of Effect Size). For the PSI, and FILE, the numerator for the ES is calculated as: Less Intensive minus More Intensive as lower scores are preferred.

Covariate Selection

Effects for the measures of family and child functioning were obtained using an analysis of covariance procedure completed using SPSS 6.0 for Windows. Analysis of covariance procedures were used to increase the statistical power of the study by reducing error variance and adjusting for any pre-intervention differences which were moderately or highly correlated with the outcome variables. In either application, the degree to which analysis of covariance is useful depends on the correlation between the covariate(s) selected and the outcome variable for which analyses are being done. However, since one degree of freedom is lost for each covariate used, it is generally best to use a limited number of covariates (usually fewer than five) in any given analysis.

All pretest and demographic variables were considered as potential covariates. The final covariate selection depended on a judgment of which variable or set of variables could be used to maximize the correlation or multiple correlation with the outcome variable in question and still include those demographic or pretest variables for which there were the largest pretreatment differences. For example, BDI pretest personal/social score and FACES adaptation scores were used as covariates for 12-month Cooper Farran Interpersonal Social Skills Scores. The combination of these variables reduced the amount of unexplained variance in the 12-month Cooper Farran scores more than other combinations of pretest and demographic variables. In each analysis, the specific covariates used are indicated in the accompanying table.

Although sample sizes for this study are as large or larger than previous early intervention studies, the statistical power of the analysis was still a concern. By setting the alpha level for all tests of statistical significance at $\alpha \leq .10$, and by using analysis of covariance procedures, the statistical power of the analyses was substantially increased. According to Hopkins (1973) and Cohen (1977), in those cases where a covariate or set of covariates could be found which correlated with the dependent variable by at least .70 (which was almost the case in these analyses), and with alpha set at $\propto \leq .10$, the statistical power was approximately 97% for finding moderate-sized differences (defined by Cohen as differences of a half a standard deviation).

Analysis of Child Functioning for Reassessments #1-#6

Reassessment #1. Twenty-three child functioning variables were examined and are presented in Table 4.12 Ten of the child functioning measures were statistically significant ($\propto \leq .10$). Eight of the ten statistically significant differences favored the more intensive group and three of these were measures of sensorimotor development. The BDI cognitive and total scores also favored the experimental subjects as did the teacher ratings of general and physical development. However, parent ratings of general development favored the less intensive group, which contradicts some of the teacher ratings and BDI scores.

The Cooper-Farran Behavior Rating Scale (CFBRS) measure of Interpersonal Skills demonstrated statistically significantly better personal/social skills for subjects in the less-intensive group as demonstrated in classroom situations. The CFBRS finding in the area of interpersonal skills was different from the results for the BDI personal/social domain. This may have occurred because the teacher completed the CFBRS, whereas the parent reported on personal/social skills for the BDI. However, parents rated children in the more-intensive program more negatively on subscales of the Perceptions of Developmental Status (PODS) that are most closely related to the BDI personal/social subscale. Only the parent PODS measure of general development was statistically significant and favored the less-intensive group subjects. The other subscales favored the more-intensive group.

The results from the first year reassessment suggest that the more-intensive intervention resulted in higher motor functioning (ES = .38) and may have resulted

Table 4.12
Results of Child Functioning for Jordan Intensity Study

		Less Intensive				More Intensive						
Variable	Covariates*	$\bar{x}$	(SD)	Adj $\bar{x}$	n	$\bar{x}$	(SD)	Adj $\bar{x}$	n	ANCOVA F	P Value	ES*
Reassessment #1												
Age in months at reassessment		57	6.8	--	29	57	7.9	--	25	0.10	.75	.00
Battelle Developmental♦ Inventory												
Personal Social	1	110.4	(27.0)	109.8	28	114.4	(22.7)	115.0	25	1.74	.19	.19
Adaptive Behavior	2	72.4	(14.9)	73.7	28	76.7	(9.8)	75.4	25	.93	.34	.11
Motor	3	98.5	(20.1)	100.1	28	106.4	(18.1)	104.7	25	3.98	.05	.23
Communication	4	54.6	(16.0)	54.1	28	54.4	(13.1)	54.9	25	.11	.74	.05
Cognitive	5	44.9	(12.2)	45.0	28	48.4	(11.8)	48.3	25	3.88	.05	.27
TOTAL	6	380.6	(73.0)	383.0	28	400.3	(57.9)	397.9	25	4.85	.03	.20
Joseph TOTAL	4	17.3	(3.1)	17.3	28	18.2	(5.3)	18.3	24	.90	.35	.32
Cooper-Farran Behavior Rating Scale (CFBRS)												
Interpersonal Skills	6	6.3	(1.8)	6.3	23	5.4	(1.6)	5.4	23	3.66	.06	-.50
Work-related skills	6	3.8	(1.0)	3.9	28	3.8	(1.0)	3.8	23	.04	.85	-.10
Perceptions of Developmental& Status												
Teacher												
General Development	6	2.9	(.9)	2.9	28	3.2	(.6)	3.2	23	4.48	.04	.33
Communication	5	3.2	(.7)	3.2	28	3.3	(.6)	3.3	25	.47	.50	.14
Sensorimotor	3	3.9	(.6)	4.0	28	4.4	(.4)	4.3	25	15.74	.00	.50
Physical	3	3.9	(1.0)	3.9	28	4.2	(.6)	4.2	23	4.94	.03	.30
Self Regulation	6	3.5	(.9)	3.5	28	3.6	(1.0)	3.6	23	.22	.64	.11
Cognition	5	2.7	(1.0)	2.7	28	3.0	(.8)	3.0	25	1.43	.24	.30
Self-Social	6	3.2	(1.0)	3.2	28	3.5	(.8)	3.5	25	2.03	.16	.30
Parent												
General Development	6	3.6	(.8)	3.6	28	3.3	(.7)	3.2	24	2.85	.10	-.50
Communication	1,9,12	3.6	(.6)	3.5	28	3.6	(.7)	3.7	24	2.75	.10	.33
Sensorimotor	3	4.1	(.5)	4.2	28	4.4	(.4)	4.4	23	5.54	.02	.40
Physical	2	4.3	(.5)	4.4	28	4.4	(.5)	4.3	24	.02	.90	-.20
Self Regulation	1	4.0	(.6)	4.0	28	3.9	(.8)	3.9	24	.52	.48	-.17
Cognition	1,7,9	3.6	(.8)	3.6	28	3.5	(.8)	3.5	24	.05	.82	-.13
Self-Social	6	3.9	(.5)	3.9	28	3.8	(.8)	3.7	24	.83	.37	-.40
Reassessment #2												
Age in months at posttest	----	68.9	(6.9)	---	28	69.8	(6.7)	---	25	1.1	.62	.13
Battelle Developmental♦ Inventory												
Personal/Social	1	133.2	(28.6)	132.6	28	131.0	(23.3)	131.5	25	.05	.82	-.04
Adaptive Behavior	2	84.0	(16.3)	85.1	28	84.0	(12.9)	83.0	25	.43	.51	-.13
Motor	3	113.6	(28.4)	115.8	28	122.0	(21.4)	119.9	25	1.69	.20	.14
Communication	4	66.2	(18.6)	65.7	28	65.2	(14.0)	65.7	25	.00	.99	.00
Cognitive	5	61.1	(23.2)	61.3	28	58.3	(16.1)	58.1	25	.97	.33	-.14
TOTAL	6	458.1	(99.0)	460.9	28	460.5	(69.2)	457.7	25	.07	.79	-.03
Joseph TOTAL	6,20	23.1	(6.0)	23.0	28	21.7	(5.5)	21.9	23	.69	.41	-.18
Cooper-Farran Behavior Rating Scale (CFBRS)												
Interpersonal Skills	6	5.2	(1.1)	5.2	28	4.6	(1.5)	4.6	23	4.05	.05	-.55
Work-related skills	6	3.7	(1.2)	3.7	28	3.8	(1.3)	3.8	23	.00	.98	.08
Teacher Developmental SPECS												
Communication	5,16	6.5	(1.6)	6.4	28	6.3	(1.4)	6.5	21	.06	.81	.06
Sensorimotor	3	16.1	(2.2)	16.2	28	16.8	(2.2)	16.7	23	1.12	.30	.23
Physical	3,19	12.5	(2.1)	12.8	28	12.9	(2.2)	12.6	23	.17	.68	-.10
Self Regulation	16	15.1	(3.3)	14.9	28	14.0	(4.1)	14.3	21	.33	.57	-.18
Cognition	5,16	6.0	(2.5)	5.9	28	6.1	(1.9)	6.2	21	.41	.53	.12
Self-Social	6,20	13.1	(3.9)	12.9	28	13.7	(4.1)	13.9	23	1.33	.26	.26
Parent Development SPECS												
Communication	5	7.5	(1.6)	7.5	28	6.7	(1.2)	6.7	23	5.14	.03	-.50
Sensorimotor	3	17.6	(2.0)	17.8	28	17.9	(1.4)	17.8	24	.01	.94	.00
Physical	3,13,21	13.3	(1.1)	13.3	27	13.4	(1.4)	13.4	23	.27	.61	.09
Self Regulation	23	16.1	(2.6)	16.3	28	15.1	(2.7)	14.9	24	3.53	.07	-.54
Cognition	5,16,20	7.8	(1.6)	7.6	28	7.1	(1.8)	7.3	24	.75	.39	-.19
Self-Social	6,18	16.1	(2.2)	16.3	27	15.2	(3.2)	15.1	20	3.94	.05	-.55

♦ = Analysis was based on raw scores

& = Predecessor to Developmental SPECS

(continued)

# Lower scores on the problem behavior scale of the SSRS are considered better. Thus, the effect size sign is reversed showing positive effects for the more-intensive group.

+ Covariates: 1 = BDI Personal Social, 2 = BDI Adaptive Behavior, 3 = BDI Motor, 4 = BDI Communications, 5 = BDI Cognitive, 6 = BDI Total, 7 = FACES Adaptation, 8 = FACES Cohesiveness, 9 = PSI Child Related, 10 = PSI Other Stress, 11 = PSI Total, 12 = Mother's years of Education, 13 = Father's years of Education, 14 = Adults in Home Attending School, 15 = Occupation of Mother, 16 = Occupation of Father, 17 = Hours Worked by Mother, 18 = Hours Worked by Father, 19 = No. of Siblings Living at Home, 20 = Hours of Daycare, 21 = Income, 22 = FRS External Support Score, 23 = FRS Total Score, 24 = FILE Total, 25 = Birth Order of Child, 26 = Child Age at Pretest, 27 = Gender, 28 = BDI Gross Motor

^ Effect Size (ES) is defined here as the difference between the groups (More Intensive minus Less Intensive) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation of the Less Intensive Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size).

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Table 4.12 (continued)

		Less Intensive				More Intensive						
Variable*	Covariates*	$\bar{x}$	(SD)	Adj $\bar{x}$	n	$\bar{x}$	(SD)	Adj $\bar{x}$	n	ANCOVA F	P Value	ES*
Reassessment #3												
Age in months at assessment		80.3	(6.9)		28	80.7	(6.8)		25	.05	.83	.06
Woodcock-Johnson Revised Achievement Test												
Broad Knowledge Total	4,27	452.2	(23.0)	450.0	28	451.4	(15.8)	453.6	25	1.20	.28	.16
Skills Knowledge Total	6,16	400.4	(45.6)	399.9	28	412.1	(30.2)	412.5	23	2.75	.10	.28
Scales of Independent Behavior												
Motor	3	448.4	(29.3)	450.4	28	459.0	(22.4)	457.0	25	2.05	.16	.23
Social/Communication	6	454.0	(20.6)	454.4	28	457.6	(11.9)	457.1	25	.55	.46	.13
Personal Living	6,20	460.6	(16.3)	460.9	28	466.4	(12.2)	466.1	25	2.75	.10	.32
Community Living	27	438.4	(23.8)	438.2	28	443.2	(17.4)	443.4	25	1.55	.22	.22
Total	6,20,9	450.5	(18.7)	451.0	28	456.6	(13.1)	456.1	25	2.74	.10	.27
Parent Developmental SPECS												
Communication	20,9,1	7.4	(1.2)	7.3	27	7.3	(1.2)	7.4	25	.12	.73	.08
Sensorimotor	6,20	17.4	(2.2)	17.3	27	17.8	(1.6)	17.8	25	1.05	.31	.23
Physical	6,9,19	13.0	(1.6)	13.0	27	13.2	(1.4)	13.1	25	.04	.85	.06
Self-Regulation	20,9,1	16.2	(2.4)	16.0	27	15.2	(3.5)	15.4	25	.93	.34	-.25
Cognition	20,9,1	7.3	(1.6)	7.1	27	7.6	(1.7)	7.7	25	2.47	.12	.38
Self-Social	20,9,1	15.9	(2.8)	15.7	27	15.2	(3.1)	15.4	25	.13	.72	-.11
Teacher Developmental SPECS												
Communication	9,1	6.5	(1.5)	6.4	26	8.0	(6.1)	8.0	24	1.76	.19	1.07
Sensorimotor	3	15.4	(2.2)	15.6	26	17.3	(2.0)	17.1	24	10.92	.01	.68
Physical	6,20,7	12.3	(2.0)	12.2	26	12.8	(1.8)	12.9	24	1.98	.17	.35
Self-Regulation	9,1,15	14.8	(3.2)	15.0	23	15.2	(3.3)	15.0	23	.25	.62	.13
Cognition	6,20	6.2	(1.7)	6.2	26	6.3	(1.9)	6.4	24	.16	.69	.12
Self-Social	20,1	14.2	(3.0)	14.1	26	14.8	(2.7)	14.9	24	1.32	.26	.27
Social Skills (SSRS)												
Parent evaluation of:												
social skills	1,23	79.7	(13.2)	80.5	26	85.3	(21.9)	84.5	25	.82	.37	.30
problem behaviors*	11	102.3	(13.1)	101.9	27	109.0	(19.0)	109.4	24	3.64	.06	-.57
Teacher evaluation of:												
social skills	6	85.5	(11.7)	86.0	25	87.7	(13.7)	87.2	24	.13	.72	.10
problem behaviors*	1	106.0	(14.6)	106.0	26	112.5	(14.3)	112.4	24	2.63	.11	-.44
academic comp.	6,19,11	82.1	(10.4)	82.6	26	86.9	(12.4)	86.3	24	1.38	.25	.36
Perceived Competence and Social Acceptance												
Cognitive competence	6	21.6	(2.4)	21.4	22	20.5	(3.4)	20.7	23	.76	.39	-.29
Physical competence	21	20.8	(3.3)	20.8	22	19.7	(4.2)	19.7	23	.56	.46	-.33
Social acceptance by peers		18.7	(4.7)		22	18.5	(3.4)		23	.02	.90	-.04
Social Acceptance by mother		18.8	(4.5)		22	19.1	(4.1)		23	.06	.81	.07
Reassessment #4												
Age in months at reassessment		91.8	(6.9)		28	92.4	(6.6)		25	.07	.78	.09
Woodcock-Johnson Revised Achievement Test												
Broad Knowledge Total	4,27	460.0	(22.3)	457.9	28	461.4	(13.6)	463.6	23	2.78	.10	.26
Skills Knowledge Total	6,16	422.1	(42.3)	421.5	28	431.0	(32.9)	431.7	23	1.75	.19	.24
Scales of Independent Behavior												
Motor	3	454.4	(27.9)	456.0	28	467.0	(12.5)	465.4	25	5.75	.02	.34
Social/Communication	6	463.3	(16.1)	463.6	28	460.5	(15.3)	460.2	25	.94	.34	-.21
Personal Living	6	462.9	(23.4)	463.2	28	470.3	(11.5)	469.9	25	2.17	.15	.29
Community Living	6,27	445.8	(22.9)	445.5	28	450.2	(16.2)	451.0	25	2.26	.14	.26
Total	6	456.5	(18.7)	456.9	28	461.8	(11.7)	461.4	25	2.10	.15	.24
Teacher Developmental SPECS												
Communication	1	6.5	(1.5)	6.5	26	6.7	(1.0)	6.7	24	.20	.66	.13
Sensorimotor	3,26	15.5	(2.9)	15.6	26	17.0	(2.1)	16.9	24	4.25	.05	.45
Physical	6,9,20	12.6	(1.5)	12.6	26	12.4	(1.8)	12.4	24	.15	.70	-.13
Self-Regulation	1,20,22	14.8	(3.3)	14.9	26	14.7	(3.7)	14.7	24	.12	.73	-.06
Cognition	6,7,20	6.3	(2.2)	5.9	26	6.7	(2.0)	6.8	24	2.83	.10	.41
Self-Social	1,20	14.2	(3.5)	13.9	26	14.5	(3.1)	14.7	24	1.00	.32	.23
Social Skills (SSRS)												
Parent evaluation of:												
social skills	1,23	84.1	(15.5)	85.3	26	83.8	(20.2)	82.6	25	.35	.56	-.17
problem behaviors*	11	104.4	(17.5)	103.9	27	109.9	(18.4)	110.4	24	2.01	.16	-.37
Teacher evaluation of:												
social skills	6	88.8	(12.8)	89.1	26	90.0	(14.7)	89.6	24	.02	.89	.04
problem behaviors*	1	110.3	(15.1)	110.3	26	108.3	(14.3)	108.3	24	.27	.60	.13
academic Comp.	6	87.0	(12.9)	87.1	27	87.5	(10.1)	87.4	23	.01	.94	.02
Perceived Competence and Social Acceptance												
Cognitive competence	6	19.2	(4.2)	19.1	26	19.3	(3.7)	19.4	25	.09	.77	.07
Physical competence	21	17.8	(5.1)	17.5	26	19.8	(4.3)	20.1	25	4.44	.04	.51
Social acceptance by peers		17.3	(4.3)		26	18.4	(4.2)		25	.98	.33	.26
Social Acceptance by mother		16.4	(4.3)		26	17.2	(4.2)		25	.51	.48	.19

(continued)

Table 4.12 (continued)

Variable'	Covariates'	Less Intensive $\bar{x}$	(SD)	Adj $\bar{x}$	n	More Intensive $\bar{x}$	(SD)	Adj $\bar{x}$	n	ANCOVA F	P Value	ES'
Reassessment #5												
Age in months at assessment		104.0	(6.8)		28	104.4	(6.6)		25	.07	.80	.06
Woodcock-Johnson Revised Achievement Raw Scores for:												
Broad Knowledge Total	4,27	466.8	(23.7)	464.6	28	469.7	(15.0)	471.9	25	3.74	.06	.31
Skills Knowledge Total		437.6	(42.1)	436.5	28	445.4	(32.7)	446.5	23	1.74	.19	.24
Scales of Independent Behavior												
Motor	3	457.0	(28.7)	458.9	28	467.9	(21.2)	466.0	25	2.64	.11	.25
Social/Communication	6	466.1	(19.2)	466.5	28	469.0	(14.8)	468.6	25	.29	.59	.11
Personal Living	6	472.9	(17.1)	473.2	28	474.0	(12.9)	473.7	25	.02	.88	.03
Community Living	6,27	455.0	(21.6)	454.5	28	452.8	(16.8)	453.3	25	.10	.76	-.06
Total	6,20	462.6	(18.3)	461.3	28	466.0	(13.4)	467.4	25	3.91	.05	.33
Social Skills (SSRS)												
Parent evaluation of:												
social skills	1,23	86.3	(13.5)	87.0	27	85.9	(23.0)	85.2	25	.15	.70	-.13
problem behaviors[*]	11	105.5	(13.9)	105.2	27	110.0	(18.5)	110.2	25	1.52	.22	-.36
Teacher evaluation of:												
Social Skills		85.6	(9.4)	85.6	26	90.3	(13.2)	90.3	20	1.97	.17	.50
Problem Behaviors[*]		110.7	(12.9)	110.3	26	113.4	(15.4)	113.4	20	.43	.51	-.21
Academic Comp.	6	82.7	(10.5)	82.8	26	90.1	(8.6)	90.1	20	6.55	.01	.70
Perceived Competence and Social Acceptance												
Cognitive competence	6	18.9	(4.8)		28	20.6	(4.4)		25	1.73	.19	.35
Physical competence	28	18.0	(5.3)	18.3	28	20.7	(4.5)	20.4	25	3.44	.07	.40
Social acceptance by peers		16.5	(5.0)		28	18.4	(4.4)		25	2.13	.15	.38
Social Acceptance by mother by Mother		15.2	(5.0)		28	16.4	(5.5)		25	.68	.42	.24
Reassessment #6												
Age in months at reassessment		116.3	(6.9)		27	116.6	(6.5)		25	.02	.89	.04
Woodcock-Johnson Revised Achievement												
Broad Knowledge Total	4,27	473.4	(23.2)	471.0	27	475.2	(16.4)	477.6	25	2.58	.12	.28
Skills Knowledge Total	6,16	449.6	(41.9)	448.2	27	455.9	(30.9)	457.3	23	1.25	.27	.22
Scales of Independent Behavior												
Motor	3	462.0	(30.2)	464.0	26	474.3	(22.5)	472.3	24	2.81	.10	.28
Social/Communication	6	474.5	(19.7)	474.8	27	474.8	(14.7)	474.6	24	.00	.97	-.01
Personal Living	6	480.1	(19.2)	480.4	27	480.4	(11.3)	480.2	24	.00	.96	-.01
Community Living	6,27	458.4	(22.6)	457.5	27	461.7	(17.4)	462.6	24	1.48	.23	.23
Total	6,20	469.2	(19.3)	468.3	27	473.0	(13.7)	474.0	24	2.64	.11	.30
Social Skills (SSRS)												
Parent evaluation of:												
Social Skills	1,23	87.0	(16.0)	88.7	27	88.9	(21.7)	87.2	24	.11	.74	-.09
Problem Behaviors	11	139.1	(161.0)	139.1	27	110.9	(17.7)	110.9	24	.71	.41	.18
Teacher evaluation of:												
Social Skills	1,9	86.9	(13.1)	86.9	22	87.1	(12.5)	87.1	17	.00	.97	.02
Problem Behaviors	11	111.3	(14.0)	111.3	22	111.2	(11.9)	111.2	17	.00	.97	-.01
Academic Comp.	6	80.5	(8.2)	80.6	22	85.7	(12.0)	85.6	17	2.38	.13	.61
Perceived Competence and Social Acceptance												
Cognitive Competence	6	19.3	(3.0)		27	18.8	(5.4)		24	.13	.72	-.17
Physical Competence	28	18.4	(3.7)	18.6	27	19.9	(5.1)	19.8	24	1.16	.29	.32
Social Acceptance by Peers		16.5	(3.0)		27	16.7	(5.3)		24	.02	.90	.07
Social Acceptance by Mother		14.6	(3.1)		27	15.4	(5.7)		24	.42	.52	.26

in higher cognitive and overall development. However, the average effect size across the ten statistically significant measures only equaled .16. Although the majority of the effect sizes (16 of 23) are positive and favor the more-intensive group, 30% are negative and have an average effect size of .09. Also, given the additional communication therapy provided to children in the more-intensive intervention, differences in communication functioning would be expected and were not observed.

Reassessment #2. Examination of the same measures of child functioning at Reassessment #1 revealed that fewer statistically significant differences existed one year later. Using a p-value of .10, four statistically significant differences emerged. All four favored the less-intensive group, three of them were reported by the parents.

Teachers reported the children in the less-intensive group, as a whole, showed more appropriate interpersonal skills (as measured by the Cooper-Farran Behavior Rating Scale) than the children in the more-intensive group. This result is interesting in that it was one of the only consistent, statistically significantly different results repeated at each reassessment. Furthermore, it was not collaborated by other scales purportedly measuring similar constructs. Neither the children or teachers reported any statistically significant group differences on the BDI or Developmental SPECS.

The parents maintained a statistically significant group difference favoring the less-intensive group on the communication scale of the parent version of the Developmental SPECS. This scale partially validates the earlier CFBRS finding, but it was not reflected in the other scales completed with the children, parents, or teachers.

This was the second year the interpersonal skills scale of the Cooper-Farran Behavior Rating Scale showed statistically significant group differences. This suggests children in the less-intensive group may, on the average, have shown more positive interpersonal skills through time. Whether the difference was a factor of the intervention or other variables, including their families or classroom dynamics, was not clear. The work-related subscale did not show differences at either reassessment.

None of the differences which favored the more intensive group at Reassessment #1 appeared for the same measures at reassessment #2. The BDI motor, BDI cognitive, BDI Total, and teacher and parent SPECS sensorimotor differences measured at Reassessment #1 failed to reach significance at reassessment #2.

Reassessment #3. At reassessment #3 several measures were added to the assessment battery. The Woodcock-Johnson Revised Achievement Test (WJ-R) and the Scales of Independent Behavior (SIB) replaced the BDI as the primary measure of children's developmental functioning. In place of the CFBRS, the Social Skills Rating System (SSRS) was used. The Joseph inventory was also replaced with the Perceived Competence and Social Acceptance Scale. Of the 28 measures of child functioning presented in Table 4.12 for reassessment #3, the more-intensive group scored higher on 22 measures, and the less-intensive group scored higher on 6 measures. Five scores showed statistically significant differences ($\alpha \leq .10$) between the groups. Of these, four favored the more-intensive group (the teacher SPECS sensorimotor score, the Scales of Independent Behavior motor skills, personal living skills, and total score) and one favored the less-intensive group (the parent evaluation of problem behaviors from the SSRS). The SIB motor skills result was consistent with the Teacher SPECS sensorimotor score, the Parent SPECS, showed no statistically significant difference between the groups. Interestingly, the teacher evaluation of problem behaviors on the SSRS did not indicate statistically significant differences between the groups, whereas the parent evaluation did. The average effect size across all 28 measures was .10.

Reassessment #4. The significant differences in motor skills observed at Reassessments #1 and #3 appeared again at the fourth reassessment (see Table 4.12). Both the SIB and the Teacher SPECS showed statistically significant differences on motor skills in favor of children in the more-intensive group. The parent evaluation of problem behaviors on the SSRS also continued to favor the less-intensive group. These results were not statistically significant and suggested that the earlier differences between the groups on interpersonal social skills diminished over time or were measured differently. Statistically significant differences were also found on the PCSA. Children in the more-intensive group perceived themselves to be more physically competent than the children in the less-intensive group. This may have been an accurate perception given the differences in motor skills reported by the teacher and parents.

The teachers also reported a statistically significant difference favoring the more-intensive group on the cognition scale of the Developmental SPECS. The children in the more-intensive group also scored better on the broad knowledge scale of the WJ-R.

The observed differences at this reassessment favored the more-intensive intervention group on 16 of the 22 measures. However, the average effect size was .13, showing only a small overall advantage.

Reassessment #5. The group difference on the WJ-R at reassessment #4 continued at reassessment #5. In addition the teachers rated children in the more-intensive group statistically significantly as showing greater amounts of academic competence. The two scores collaborate each other at this reassessment but did not do so at earlier reassessments.

The group differences previously found on the motor scale of the SIB were not present for this reassessment, though the score still favored the more-intensive group. The children still perceived themselves as more physically competent (as measured by the PCSA), and that difference continued to be statistically significant.

Parents reported their children in the more-intensive intervention group were also doing better than their peers in the less-intensive group on independent behaviors. The effect size for the total SIB score was .33. There was a trend again favoring the more-intensive group across measures at reassessment #5. The average effect size was small (ES = .19) but consistent with the previous reassessments favoring the more-intensive intervention group.

Reassessment #6. The motor subscale of the Scales of Independent Behavior was statistically significant between groups again at reassessment #6. The subscale favors the more-intensive group, suggesting an increased ability in motor skills. This finding has been somewhat consistent since reassessment #3 and was reported earlier on different measures at reassessments #1 and #2. Each of these measures has used parental report as the method of data collection and did not directly assess the children. The Jordan Intensity Study has not gathered a direct measure of motor development since reassessment #2, but has relied on parental report. Parental reports seem to be credible because as parents are typically with their children more than an assessor and the finding is so consistent.

Group differences in other child development measures at reassessment #6 were not statistically significant. The children's perceived competence as measured by the Pictorial Scale of Perceived Competence and Social Acceptance (PCSA) did not show a difference on any of the subscales as it had in previous years. This may be attributed to the age of the children reaching the upper limit of the PCSA. The scales generally have lower scores for both groups than at any time since the scale was administered. The items presented to the children may not be differentiating their social competence in a manner that is appropriate for them. The measures of academic competence and communication skills were also not statistically significant. Again, the study does not directly measure communication skills but relies on parental report.

Effects of Alternative Forms of Intervention on Measures of Family Functioning

Several measures of family functioning were gathered throughout the study. While families were not differentially involved in the intervention, the intervention theoretically impacted family life. As children with disabilities increased in developmental functioning, the impact on family functioning should have been positive. Furthermore, changes in family functioning may have changed differentially because of the small increase in the amount of time available to parents of children in the more-intensive group. Table 4.13 provides a summary of the measures assessing family functioning through reassessment #6.

Parental stress. At each of the six reassessments parents completed the Parenting Stress Index (PSI). For the first three reassessments they completed the long form and then switched to the short form for reassessments #4 - #6. The only statistically significant differences were found at reassessment #1 where the more-intensive group reported less stress related to their children and other things in general than the less-intensive group. The PSI total score favored the children in the more-intensive group, though not statistically significantly. The average effect size for the PSI at reassessment #1 was .38.

Subsequent reassessments did not show statistically significant differences. At reassessments #2, #3, #4, and #6 the effect sizes favored the less-intensive group to a small degree. At reassessment #5 neither group showed an advantage. Across reassessments the average effect size for the PSI showed a slight advantage for the less-intensive group at -.05. Apparently the intervention had an immediate benefit on the perceived stress for parents of children in the more-intensive intervention, but the advantage did not endure through time.

Family support. Perceptions of family support was gathered each year from a questionnaire the mothers typically completed. Statistically significant differences did not emerge at any reassessment although the scores favored the less-intensive group at each reassessment except #2. The average effect size across the six reassessments was -.09. Apparently the intervention did not affect the parents perceptions of support.

Other family measures. The FACES was administered at reassessments #1 and #2. Directly following the intervention families in the more-intensive group reported statistically significantly more adaptability than families in the less-intensive

Table 4.13

Reassessment #1 Results of Family Functioning for Jordan Intensity Study

		Less Intensive					More Intensive							
Variable	Covariates[+]	$\bar{x}$	(SD)	Adj$\bar{x}$	%ile	n	$\bar{x}$	(SD)	Adj$\bar{x}$	%ile	n	ANCOVA F	p Value	ES[*]
Reassessment #1														
Parenting Stress Index[**] (PSI)														
Child Related (range 47 to 235)	2,4,10	118.4	(26.4)	119.2	85	28	112.0	(22.5)	111.2	79	25	2.92	.09	.30
Other Related (range 54 to 270)	5,7	130.5	(17.4)	128.6	63	28	117.2	(26.1)	119.2	46	25	5.13	.03	.54
TOTAL (range 101 to 515)	6,10	248.9	(38.7)	245.0	76	28	229.2	(43.2)	233.1	61	25	2.52	.12	.31
Family Support Scale TOTAL	8	29.0	(12.2)	28.6		28	27.4	(11.0)	27.8		25	.18	.67	-.07
Family Adaptability and Cohesion Evaluation Scale														
Cohesion	12	40.0	(3.5)	40.9		28	42.0	(6.0)	41.0		25	.00	.96	-.03
Adaptability	16,17	25.7	(4.4)	26.0		28	24.0	(4.2)	23.6		25	5.81	.02	-.55
Reassessment #2														
Parenting Stress Index (PSI)[**]														
Child Related	4	110.0	(26.2	110.7	75	28	115.8	(23.6)	115.1	82	25	.67	.42	-.17
Other Related	5	125.6	(20.3)	122.8	48	28	122.0	(32.5)	124.7	61	24	.12	.73	-.09
TOTAL	6,10	235.6	(41.6)	233.1	65	28	237.7	(51.4)	242.8	71	24	1.40	.24	-.23
Family Support Scale TOTAL	8	26.5	(9.2)	26.3		27	28.9	(11.4)	29.1		24	1.59	.21	.30
Family Adaptability and Cohesion Evaluation Scales														
Cohesion	12	40.0	(4.1)	41.0		28	41.6	(5.7)	40.6		25	.12	.73	-.10
Adaptability	16,17	25.6	(5.7)	25.9		28	24.9	(4.6)	24.6		25	1.09	.30	-.23
Reassessment #3														
Parenting Stress Index (PSI)														
Child Related	4	112.0	(27.1)	110.0		23	106.3	(25.1)	108.3		16	.08	.77	.06
Other Related	5	120.2	(25.5)	116.5		23	117.3	(25.3)	121.0		16	.42	.52	-.18
Total	6,10	232.2	(47.8)	226.0		23	223.6	(47.8)	229.8		16	.09	.77	-.08
Family Support Scale TOTAL	6	27.8	(9.1)	27.6		28	26.3	(11.8)	26.5		25	.18	.67	-.12
Parent Self-Awareness Scale TOTAL	8,9	42.6	(6.7)	42.8		28	43.8	(7.1)	43.7		25	.23	.63	.13
Family Functioning (CEFF)[♦]														
Time Demands	13	12.0	(4.8)	12.5		25	13.4	(4.5)	12.9		25	.13	.72	-.08
Acceptance-Problems	3,4,10	.9	(1.4)	1.0		27	1.5	(2.4)	1.5		25	.86	.36	-.36
Coping	4,9	17.0	(4.5)	17.1		27	14.2	(5.1)	14.1		25	5.59	.02	.67
Social Relationship	3,4	12.8	(4.0)	13.0		27	13.3	(5.1)	13.1		24	.02	.88	-.03
Financial	3,4	4.5	(2.9)	4.5		27	3.5	(2.2)	3.5		24	3.05	.09	.35
Well-Being	3,4	14.0	(3.8)	14.0		27	14.3	(3.0)	14.2		25	.06	.81	-.05
Sibling Relationship	4,9	23.9	(8.3)	23.3		27	23.0	(11.3)	23.7		25	.02	.90	-.05
Situational Stress	13,3,4	19.5	(7.9)	20.3		27	18.3	(7.2)	17.5		25	2.49	.12	.35
Total CEFF	13,3,4	84.2	(15.4)	85.8		25	83.1	(21.4)	81.5		25	1.00	.32	.28
Reassessment #4														
Parenting Stress Index[**] (Short Form) (PSISH)														
Parent Distress	7,14	25.1	(7.3)	25.0	50	27	25.3	(8.5)	25.4	55	24	.03	.86	-.06
Parent/Child Dysfunction	11,14	22.8	(5.5)	23.4	65	27	24.0	(7.2)	23.4	80	24	.00	1.00	.00
Difficult Child	6	29.4	(10.3)	29.1	70	27	31.1	(9.4)	31.4	80	25	.98	.33	-.22
Total Score	9,15	77.5	(18.5)	77.2	73	27	81.2	(23.5)	81.6	80	25	.70	.41	-.24
Family Support Scale TOTAL	6	32.3	(13.4)	32.0		28	28.4	(12.1)	28.7		25	1.20	.28	-.25
Parent Self-Awareness Scale TOTAL	8,9	41.9	(6.4)	42.1		28	42.5	(8.4)	42.3		25	.01	.92	.03

(continued)

[**] Analyses for the PSI are based on raw scores. Lower scores are considered better.

[*] Effect Size (ES) is defined here as the difference between the groups (More Intensive minus Less Intensive) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation of the Less Intensive Group (see Glass, 1976; Tallmadge, 1977 and Cohen, 1977 for a more general discussion of the concept of Effect Size).

[+] Covariates: 1 = BDI Personal/Social, 2 = BDI Adaptive Behavior, 3 = BDI Total, 4 = PSI Child Related Stress, 5 = PSI Other Stress, 6 = PSI Total, 7= FRS Total, 8 = FSS Total (mother), 9 = Income, 10 = No. of Siblings living at home, 11 = No of siblings with disabilities, 12 = FACES Cohesion, 13 = Hours Per Day child is in daycare, 14 = live with both parents, 15 = FILE Total, 16 = FACES Adaptability, 17 = BDI Fine Motor

[♦] Lower scores on the CEFF are considered better. Thus, the value of the effect size is reversed.

Table 4.13 (continued)

Reassessment #1 Results of Family Functioning for Jordan Intensity Study

Variable	Covariates*	Less Intensive					More Intensive					ANCOVA F	p Value	ES
		$\bar{x}$	(SD)	Adj$\bar{x}$	%ile	n	$\bar{x}$	(SD)	Adj$\bar{x}$	%ile	n			
Reassessment #5														
Parenting Stress Index** (Short Form) (PSI-SF)														
Parent Distress	7,14	26.0	(5.5)	26.0	55	28	25.4	(7.9)	25.4	50	24	.13	.73	-.11
Parent/Child Dysfunction	11,14	24.1	(5.5)	24.9	75	28	25.2	(7.5)	24.4	85	24	.10	.76	-.09
Difficult Child	6	30.2	(9.3)	30.0	75	28	31.1	(8.6)	31.3	80	25	.41	.53	.14
Total Score	9,15	80.4	(15.4)	80.5	77	28	82.1	(20.9)	82.0	81	25	.12	.73	.10
Family Support Scale TOTAL	6	29.9	(10.3)	29.6		28	28.0	(10.4)	28.3		25	.32	.57	-.13
Parent Self-Awareness Scale TOTAL	8.9	41.1	(6.2)	41.4		28	43.0	(8.8)	42.7		25	.61	.44	-.21
Reassessment #6														
Parenting Stress Index (Short Form) (PSISH)														
Parent Distress	7,14	24.9	(4.6)	24.8		27	24.6	(8.7)	24.7		23	.01	.94	-.02
Parent/Child Dysfunction	11,14	22.7	(5.1)	23.0		27	23.7	(5.7)	23.4		23	.06	.82	.08
Difficult Child	6	29.3	(9.2)	29.1		27	33.1	(10.6)	33.3		24	2.50	.12	.46
Total Score	9,15	76.9	(12.4)	76.6		27	80.6	(18.1)	80.9		24	1.31	.26	.35
Family Support Scale TOTAL	6	29.5	(10.4)	29.4		27	26.4	(11.0)	26.5		24	1.08	.31	-.28
Parent Self-Awareness Scale Total	8,9	44.0	(4.4)	44.8		27	44.1	(11.5)	43.3		24	.44	.51	-.34
Family Functioning Style Scale (FFSS)														
Resources	8,11	32.7	(4.5)	32.6		27	33.1	(7.5)	33.1		24	.12	.74	.11
Sharing	11,12	11.5	(2.3)	12.0		27	11.8	(3.2)	11.3		24	1.18	.28	-.30
Identity	11,12	31.3	(3.8)	32.0		27	32.3	(5.6)	31.6		24	.16	.69	-.11

group. This difference between the groups was not as discrepant at reassessment #2 although the score still favored the more-intensive group (ES = .23).

The PSAS did not show a statistically significant difference between the groups at any reassessment either. The effect sizes generally favor the more-intensive group, but the absolute values were generally quite low, ranging from .03 to 34.

Two different measures of family functioning were gathered at two different reassessments. The CEFF at reassessment #3 resulted in two statistically significant (p <.10) group differences. The coping and financial scales favored the more-intensive group and had effect sizes of 2/3 and 1/3 of a standard deviation, respectively. The average effect size for the measure was only .12, suggesting little difference between the groups on tne CEFF. At reassessment #6 the FFSS was administered and was not statistically significantly different between the groups. The average effect size across the three scales was -.10.

Summary of family measures. Apparently the intervention had little affect on families' functioning as measured by these instruments. There were few statistically significant differences between the groups and the effect sizes were generally small. Across the 47 measures gathered on the families, only 16 favored the more-intensive group and 30 favored the less-intensive group (one did not favor either group). The measures generally favored the less-intensive group, but only slightly with an average effect size of .04. Interestingly, of the five statistically significant differences, four favored the more-intensive group. The average effect size for these statistically significant measures equaled .26.

Severity Subanalysis

Many subjects in this study exhibited relatively severe disabilities. Two thirds of the children in the study displayed initial assessment BDI DQs below 65. The DQs ranged from 40 to 100. Consequently one of the issues of concern was whether there was a differential intervention impact based on the degree of delay exhibited by the children. Analysis of child severity by intensity of intervention was completed by dividing the children into mild and severe groups. The BDI raw score medians were used as the cutoff point for dividing the children. Children below the median score for each BDI domain were classified as severe and those above the median as mild. An ANOVA for the two intervention groups was conducted with the new BDI initial assessment severity variables. The more-intensive children in the severe category scored significantly lower on the BDI total score ($p = .09$) than the other three groups. None of the other interactions between severity and group on the BDI initial assessment scores were statistically significant. A group by severity of disability (2 x 2) analysis of variance was conducted for all of the child measures for the six reassessments. The results are presented in Table 4.14.

Statistically significant interactions between group and severity appear for many of the adaptive, motor, and cognitive domains. For the motor and adaptive

Table 4.14

Severity Subanalysis of Child Outcomes for Jordan Intensity Study

		Mild				Severe					
		Less Intensive		More Intensive		Less Intensive		More Intensive			
	Covariates^	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Significant main effects	Significant interaction effects
Reassessment #1											
Battelle Developmental Inventory (BDI)											
Personal/Social	12	115.1	15	121.0	11	104.4	13	110.5	14		
Adaptive Behavior	19	76.7	14	75.6	13	70.1	14	75.3	12		Yes
Motor	2	103.6	14	109.1	13	95.6	14	100.3	12	severity, group	
Communication	20	52.5	16	55.3	13	54.0	12	52.4	12		
Cognitive	10	46.3	13	48.7	14	43.5	15	47.4	11	group	
Total	1	385.5	13	403.8	14	379.7	15	389.7	11	group	
Joseph											
Total	20	16.6	13	19.0	13	17.8	15	17.4	11		
Interpersonal		7.2	13	6.5	13	5.4	15	4.2	10	severity, group	
Work Related		3.5	13	3.8	13	4.1	15	3.8	10		
Perceptions of Developmental Status											
Teacher											
General Development	1	2.7	13	2.9	14	3.1	15	3.5	11	severity, group	
Communication	20	3.3	13	3.1	14	3.0	15	3.4	11		Yes
Sensorimotor	2	4.1	14	4.3	13	3.8	14	4.4	12	group	Yes
Physical	2	4.2	14	4.1	13	3.7	14	4.2	12		Yes
Self-Regulation	1	3.6	13	3.8	14	3.4	14	3.4	11		
Cognition	10	3.0	16	2.9	13	2.2	12	2.9	12		Yes
Self-Social	1	3.4	13	3.5	14	3.1	15	3.4	11		
Parent											
General Development	1	4.0	13	3.4	13	3.3	15	3.1	11	group	
Communication	12,11,21	3.8	13	3.8	13	3.3	15	3.6	11	severity	
Sensorimotor	2	4.2	14	4.5	13	4.1	14	4.3	11	group	
Physical	19	4.4	14	4.4	13	4.3	14	4.3	11		
Self-Regulation	12	4.0	13	4.0	13	4.1	15	3.8	11		
Cognition	12,5,11	3.6	10	3.7	13	3.5	12	3.4	11		
Self-Social	1	3.8	13	3.9	13	4.0	15	3.6	11		Yes

(continued)

^ The scores used as covariates were all obtained at pretest. Covariates: 1 = BDI Personal-Social Raw, 2 = PSI Child Stress, 3 = BDI Motor Raw, 4 = BDI Total Raw, 5 = FACES Adaptability, 6 = Hours per day child is in daycare, 7 = Mother's Occupation, 8 = Number of siblings in home, 9 = Sex of child, 10 = BDI cognitive raw, 11 = PSI other stress, 12 = Hours mother works per week, 13 = FILE stress score, 14 = BDI adaptive behavior raw, 15 = Chronological age at pretest, 16 = Ethnicity of child, 17 = PSI total stress, 18 = Mother's marital status, 19 = Mother's education, 20 = FACES cohesion, 21 = Income, 22 = FSS mother total, 23 = FRS total

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Table 4.14 (continued)

Severity Subanalysis of Child Outcomes for Jordan Intensity Study

		Mild				Severe					
		Less Intensive		More Intensive		Less Intensive		More Intensive			
	Covariates[a]	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Significant main effects	Significant interaction effects
Reassessment #2											
Battelle Developmental Inventory (BDI)											
Personal/Social	12	133.2	15	131.0	11	132.6	13	132.4	14		
Adaptive Behavior	19	91.1	14	85.5	13	78.0	14	81.1	12		
Motor	2	125.0	14	123.7	13	105.0	14	116.4	12	severity group	Yes
Communication	20	68.6	16	65.1	13	60.1	12	64.4	12		
Cognitive	10	65.1	13	55.1	14	57.5	15	61.2	11		Yes
Total	1	450.0	13	442.3	14	470.0	15	474.7	11		
Joseph											
Total	1,13	25.7	13	21.3	13	20.5	15	22.9	10		Yes
Interpersonal.		5.1	13	5.0	12	5.4	15	4.1	11	group	Yes
Work Related		3.9	13	3.8	12	3.7	15	3.7	11		
Perceptions of Developmental Status											
Teacher											
Communication	10,6	7.1	13	5.9	11	5.8	15	6.9	10		Yes
Sensorimotor	2	16.8	14	16.8	12	15.5	14	16.6	11		
Physical	2,3	12.5	14	12.6	12	13.1	14	12.5	11		
Self-Regulation	6	17.0	13	16.0	11	13.4	15	12.0	10	severity	
Cognition	10,6	6.4	16	5.8	11	5.2	12	6.3	10		
Self-Social	1,13	13.3	13	13.5	12	12.5	15	14.4	11		
Parent											
Communication	10	8.4	13	7.1	13	6.8	15	6.1	10		
Sensorimotor	2	18.2	14	18.0	13	17.2	14	17.5	11	severity, group	
Physical	2,17,22	13.0	14	13.5	12	13.8	11	13.0	11		Yes
Self-Regulation	15	17.5	13	15.8	13	15.3	15	14.0	11	severity, group	
Cognition	10,6,13	7.9	16	7.4	11	7.3	12	6.7	11		
Self-Social	1,23	16.6	12	16.1	11	15.9	15	13.9	9	group	

(See footnote from previous page)

(continued)

Table 4.14 (continued)

Severity Subanalysis of Child Outcomes for Jordan Intensity Study

		Mild				Severe					
		Less Intensive		More Intensive		Less Intensive		More Intensive			
	Covariates[a]	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Significant main effects	Significant interaction effects
Reassessment #3											
Woodcock-Johnson Revised Achievement (Raw Scores)											
Broad Knowledge	9,10	455.9	13	452.5	14	446.4	15	452.0	11		
Skills Knowledge	1,6	395.7	13	407.1	13	403.4	15	418.5	10	group	
Scales of Independent Behavior											
Motor	2	449.6	14	454.7	13	450.8	14	458.8	12		
Social/Communication	3,4	460.2	13	455.7	14	449.1	15	458.9	11		Yes
Personal Living	1	468.0	14	466.8	13	453.4	14	465.3	12	severity, group	Yes
Community Living	1,9	435.4	14	435.4	13	440.8	14	451.2	12	severity	
Total	1	454.6	13	454.7	14	447.5	15	457.8	11		
Perceived Competence and Social Acceptance											
Cognitive Competence	1	21.8	15	20.2	12	20.3	7	20.8	11		
Physical Competence	17	21.9	13	19.8	12	18.8	9	20.0	11		
Social Acceptance by peers		17.9	13	19.1	12	19.8	9	17.9	11		
Social Acceptance by mother		19.3	14	19.0	10	17.9	8	19.2	13		
Teacher Developmental SPECS											
Communication	11,12	5.4	14	5.8	13	7.4	12	10.6	10	severity	
Sensorimotor	2	15.5	12	17.1	13	15.7	14	17.0	10	group	
Physical	1,5,13	13.1	12	12.9	13	11.3	14	12.9	10		
Self-regulation	11,12,14	15.2	11	15.2	14	14.1	15	15.4	8		
Cognition	1,13	6.4	14	6.2	13	5.8	12	6.5	10	severity	
Self-social	12,13	14.6	13	14.8	10	13.7	13	15.0	13		
Parent Developmental SPECS											
Communication	11,12	7.2	16	7.1	13	7.8	12	7.4	11		
Sensorimotor	2	17.9	14	17.8	13	16.9	14	17.4	11		
Physical	3,4	13.7	14	13.5	13	12.3	14	12.5	11		
Self-Regulation	11,12,14	15.6	13	15.4	14	15.9	15	15.9	9		
Cognition	2,4	7.9	13	8.2	14	6.6	15	7.2	10		
Self-Social	14,12	15.5	15	14.6	11	15.9	13	16.2	13		
Social Skill Parent											
Total Problem	12,15	13.0	12	14.2	14	14.8	14	17.7	11	severity	
Total	1	12.4	11	14.4	14	11.0	15	14.0	10		
Social Skills Teacher											
Academic Competence	1,3,16	20.3	14	23.6	13	21.2	11	26.0	11	group	

(continued)

[a] See footnote from previous page.

Table 4.14 (continued)

Severity Subanalysis of Child Outcomes for Jordan Intensity Study

		Mild				Severe					
		Less Intensive		More Intensive		Less Intensive		More Intensive			
	Covariates^	Adj. x̄	n	Adj. x̄	n	Adj. x̄	n	Adj. x̄	n	Significant main effects	Significant interaction effects
Reassessment #4											
Woodcock-Johnson Revised Achievement (Raw Scores)											
Broad Knowledge		465.4	16	464.3	13	448.6	12	460.0	12	severity	Yes
Skills Knowledge	1,6	417.7	13	429.2	13	424.5	15	434.2	10		
Scales of Independent Behavior											
Motor	2	460.2	14	462.3	13	451.1	14	468.6	12	group	Yes
Social Communication	1	467.8	13	457.1	14	459.8	15	463.9	11		Yes
Personal Living	1	467.5	14	465.2	13	458.7	14	474.8	12		Yes
Community Living	1,9	442.3	14	442.0	13	447.8	14	459.8	12	severity	Yes
Total	1	461.4	13	458.9	14	452.9	15	464.6	11		Yes
Perceived Competence and Social Acceptance											
Cognitive Competence	1	19.1	16	18.4	13	18.5	10	20.1	12		
Physical Competence	17	20.2	14	19.8	13	14.2	12	20.3	12	severity, group	Yes
Social acceptance by peers		18.4	14	18.6	13	16.0	12	18.3	12		
Social acceptance by mother		16.9	15	16.7	11	15.6	11	17.6	14		
Teacher Developmental SPECS											
Communication	11,12	6.7	15	6.9	12	6.2	11	6.4	12		
Sensorimotor	2	15.8	13	17.4	12	15.4	13	16.5	12	group	
Physical	1,5,13	11.7	13	12.1	12	13.3	13	12.9	12	severity	
Self-regulation	11,12,14	14.5	11	15.7	13	15.1	15	13.5	10		
Cognition	1,13	6.5	15	7.1	12	5.0	11	6.6	12	group	
Self-Social	12,13	14.6	12	14.4	12	13.4	14	15.2	12		
Social Skills Parent											
Total Raw	12,15	38.3	12	40.4	14	49.0	14	44.6	11	severity	
Total Behavior	16	15.2	13	16.0	13	15.7	14	16.0	11		
Social Skills Teacher											
Total Raw	1	35.8	11	39.0	13	30.5	15	29.9	11		
Total Behavior	12	16.7	11	11.2	13	11.7	15	12.2	11		
Academic Competence Total	1	24.5	16	25.7	12	22.3	11	26.7	11		

(See footnote from previous page)

(continued)

Table 4.14 (continued)

Severity Subanalysis of Child Outcomes for Jordan Intensity Study

		Mild				Severe					
		Less Intensive		More Intensive		Less Intensive		More Intensive			
	Covariates^	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Significant main effects	Significant interaction effects
Reassessment #5											
Woodcock-Johnson Revised Achievement (Raw Scores)											
Broad Knowledge	10,9	470.2	13	469.8	14	461.1	15	471.8	11		
Skills Knowledge	1,6	434.6	13	443.5	13	438.0	15	449.9	10		
Scales of Independent Behavior											
Motor	2	460.7	14	463.7	13	456.4	14	468.0	12		
Social/Communication	1	471.5	13	464.5	14	461.9	15	473.7	11		Yes
Personal Living	1	481.5	14	473.9	13	464.5	14	473.6	12	severity	Yes
Community Living	1,9	465.5	14	449.5	13	452.2	14	475.1	12		
Total	1,13	465.6	13	462.4	14	457.0	15	473.0	11	group	Yes
Perceived Competence and Social Acceptance											
Cognitive Competence	1	20.3	16	19.7	13	16.9	12	21.3	12		Yes
Physical Competence	18	19.2	14	20.4	13	17.3	14	20.4	12	group	
Social acceptance by peers		16.6	14	17.3	13	16.4	14	19.6	12		
Social acceptance by mother		14.9	15	15.5	11	15.5	13	17.0	14		
Teacher SPECS											
Communication	11,12	12.0	14	6.4	9	6.3	12	7.3	11		
Sensorimotor	2	15.0	12	16.8	9	15.3	14	16.3	11		
Physical	1,13,5	16.0	12	12.1	9	11.5	14	13.6	11		
Self-Regulation	11,12,14	12.6	11	14.7	10	14.6	15	14.5	9		
Cognition	1,13	12.0	14	6.9	9	4.5	12	7.4	11		
Self-Social	13,12	17.8	14	13.3	8	14.3	12	16.7	12		
Parent Social Skills											
Total Raw	12,15	43.9	13	42.4	14	45.9	14	46.5	11		
Total Problem	16	14.2	13	15.9	14	16.6	13	16.4	11		
Teacher Social Skills											
Total Raw		29.3	11	34.1	10	31.5	15	35.5	10		
Total Problem		15.3	11	14.1	10	13.4	15	15.8	10		
Academic Competency	1	21.0	14	25.1	9	23.0	12	29.4	11	group	

(See footnote from previous page)

(continued)

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Table 4.14 (continued)

Severity Subanalysis of Child Outcomes for Jordan Intensity Study

		Mild				Severe					
		Less Intensive		More Intensive		Less Intensive		More Intensive			
	Covariates[a]	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Adj. $\bar{x}$	n	Significant main effects	Significant interaction effects
Reassessment #6											
Woodcock-Johnson Revised Achievement (Raw Scores)											
Broad Knowledge	9,10	479.4	13	476.8	14	4674.3	14	475.9	11		Yes
Skills Knowledge	1.6	443.3	13	450.3	13	451.7	14	464.3	10		
Scales of Independent Behavior											
Motor	2	461.1	13	464.3	13	466.3	13	479.3	11		
Social/Communication	1	483.9	13	473.3	13	465.9	14	476.1	11		Yes
personal Living	1	486.5	13	478.4	13	474.3	14	482.1	11		Yes
Community Living	1,9	456.6	13	458.3	13	458.1	14	466.9	11		
Total	1,13	471.4	13	468.4	14	464.2	14	480.1	10	group	Yes
Perceived Competence and Social Acceptance											
Cognitive	1	18.9	16	18.2	13	19.5	11	19.2	11		
Physical Competence	18	18.2	14	20.2	13	18.8	13	19.2	11		
Social acceptance by peers		16.9	14	15.9	13	16.1	13	17.5	11		
Social acceptance by mother		14.1	14	17.6	11	15.1	13	13.5	13		Yes
Parent Social Scale											
Total Raw	12,15	45.6	13	44.1	14	46.2	14	47.6	10		
Total Problem	16	14.8	13	16.6	14	17.5	13	16.5	10		
Teacher Social Skills											
Total Raw		30.5	10	32.3	10	32.2	12	31.6	7		
Total Problem		16.0	10	13.3	10	12.4	12	13.4	7		
Academic Competence	1	18.9	12	21.8	9	21.2	10	25.5	8		

domains, the statistically significant differences mainly derive from the more-severe children who were in the less-intensive group placement. These children consistently scored lower when compared to their more-severe, more-intensive group counterparts. Children in the mild category generally scored about the same on these measures, regardless of group placement. More-severe children who were on the more-intensive intervention group scored about the same as the mild children across these measures and across time.

The same interaction pattern occurs for many of the self-concept measures and some of the report measures. In each case the children in the more-severe category of the more-intensive group score higher than their counterparts in the less-intensive group. The general interaction pattern is illustrated in Figure 4.2. While this is not exactly what any single interaction looked like, it is the general pattern for all the interactions.

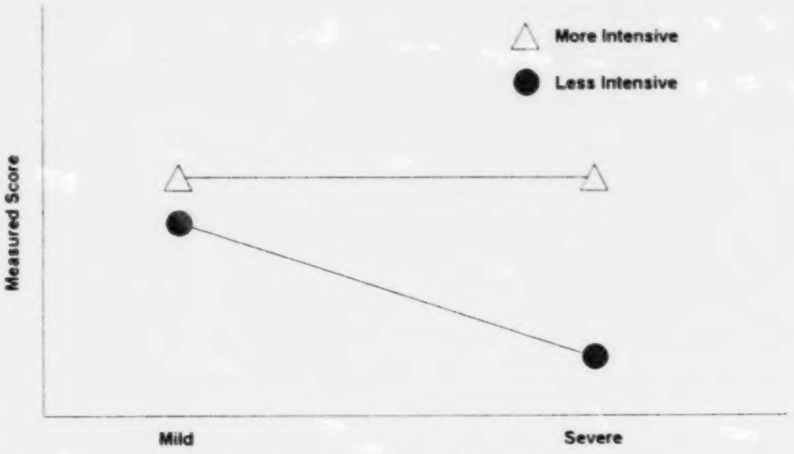


Figure 2. Pattern of Interaction Effect for Severity by Group Analysis in the Jordan Intensity Study

These results, combined with the overall group comparisons reported in Table 4.12, suggest the group differences on motor scores can largely be attributed to the difference between the more severely disabled children.

The reassessment #2 results by group (Table 4.12) showed only a few statistically significant differences between the more- and less-intensive intervention group children. The severity interaction analysis sheds some light on why there were no group differences on motor or cognitive score similar to some other reassessments. For the mild group there were statistically significant differences in favor of the less-intensive group on the BDI cognitive and total scales, the Joseph self-concept score, and the cognitive scales of the parent and teacher SPECS. For the severe children, there were statistically significant differences in favor of the more-intensive group on the BDI and Teacher SPECS motor scores. They also scored higher on the cognitive and communication domains of the Teacher SPECS. It is apparent that the more-intensive group children did not all score better on the child measures, but scored better dependent upon their degree of disability. This evidence suggests there may be differential benefits dependent on the severity of the child's disability. Children who have more severe disabilities appear to benefit at different times on motor, cognitive and possibly communication skills from more-intensive interventions. Children who are mild in their disabilities may not show as much benefit from a more-intensive intervention.

The differences between the groups continued to fade so that by reassessment #4 there were no statistically significant differences between the more- and less-intensive children with mild delays. The differences favoring the more-intensive intervention for severely delayed children were more durable. Statistically significant differences were observed on motor, and total SIB scores and for physical competence at Reassessment #4. Also, the Teacher SPECS suggests higher cognitive functioning for the more-intensive early intervention children with severe delays. At Reassessment #5, the severe more-intensive treatment subjects scored significantly higher than severe less-intensive group children on the SIB personal living scale, and the PCSAs in physical competence scale. Significant interactions were observed between intervention and severity for the SIB personal living, communication, and total scores and for perceptions of physical competence.

At reassessment #6, there were significant interactions on the communication, personal living, and total scores for the SIB. Maternal social acceptance and the broad knowledge scores were also statistically significant interactions. The same pattern occurred here as figure two represents, except for the maternal acceptance scale.

This group of analyses suggests a differential benefit for children who have more severely disabilities. The more-intensive intervention appears to have had some benefit for these children over those children who had only mild disabilities. This investigation bears further analyses and explanation.

Educational Placement

Table 4.15 outlines educational placement for the children in the two groups at reassessments #2-#6. Most of the children remained in the Jordan School District service area and received at least some intervention services through reassessment #6, although these services were not part of the intervention.

Table 4.15

Percent of Children in Early Intervention and Receiving Educational Services by Group and by Reassessment for the Jordan Intensity Study

	Less Intensive					More Intensive				
Reassessment #	2	3	4	5	6	2	3	4	5	6
Percent Receiving:										
Preschool Intervention	32	0	0	0	0	36	0	0	0	0
School Intervention	68	96.4	100	100	95.7	60	100	100	100	89.5
No Educational Services	0	3.6	0	0	4.3	40	0	0	0	10.5

After the children were old enough to be enrolled in public school programs (5 years or older), educational placement data were gathered from each teacher. Data from reassessments #3 and #4 are presented in Table 4.16. No statistically significant differences between the groups were indicated in classroom placement or the other educational service variables--which included grade retention and eligibility for special education services.

Table 4.16

Educational Placement of Jordan Intensity Subjects (as reported by the child's teacher)

	Less Intensive		More Intensive			
	$\bar{x}$	n	$\bar{x}$	n	p Value	ES
REASSESSMENT #3						
Child retained in grade	12%	26	13%	24	.92	-.03
Eligible for special education	96%	26	88%	24	.28	.40
REASSESSMENT #4						
Child retained in grade	8%	26	8%	24	.92	-.03
Eligible for special education	100%	26	96%	24	.53	.18

Effect Size (ES) is defined here as the difference between the groups (low intensity minus high intensity) on the $\bar{x}$ scores divided by the standard deviation of the Less Intensive Intervention Group (Lower scores are preferred on all 3 placement variables) (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size).

Summary and Conclusions

This study examined whether a "more intensive" center-based early intervention program would result in benefits to children and their families when compared to a "less intensive" program. Intensity was operationalized along several different dimensions. The more-intensive program provided services to children 10 hours per week in comparison to 6 hours per week for the less-intensive program; the more intensive program had a 3 to 1 child:teacher ratio, while the less intensive program had a 5 to 1 child:teacher ratio; and 5 times as much language therapy was available to children in the more-intensive group compared to the less intensive group. Other than these variables, the two intervention programs were organized similarly (e.g., curricula used, teaching styles, organizational structure, etc.) Indeed, the same teachers taught some children in each group so the quality or style of teaching would not be a confounding factor.

Obviously, intensity can be defined in a variety of different ways (e.g., duration of intervention, hours per week of intervention, percent of time engaged in learning time activities, amount of one-on-one versus group interaction, etc.) However, based on previous research, it was clear that the variables selected to define "intensity" in this study were among those most frequently thought of as contributing to "more intense" interventions. Furthermore, the treatment verification data collected as part of this study demonstrated that children in the more-intensive group did indeed receive more hours of intervention per week, were "engaged in learning" a similar percentage of time they attended (resulting in more total hours per week of engaged learning time), participated in a higher percentage of individualized and small group activities, had lower child:teacher ratios, and received more one-on-one language therapy.

This study was based on the hypothesis that children participating in the more intensive intervention would show greater developmental gains and their families would benefit in terms of reduced stress and enhanced family functioning. This hypothesis was based on the conclusions of previous early intervention literature reviews. There was also the widespread perception among practitioners, administrators, and policymakers that more intensive early intervention programs would help children who participated and their families which would result in a long-term cost savings. The position is logical based on what we know about prevention in many different areas. Unfortunately, there was very little data from methodologically sound studies to confirm or refute the hypothesis that more intensive early intervention programs would be more beneficial. Consequently, this study was designed to ensure the definition of intensity was relevant to the types of programming options available to administrators. The study was methodologically well-designed, and information was collected to document the various interventions were implemented as intended (i.e., one program was substantially more intensive than the other.)

The results after six years are surprising. There is some evidence that the more intensive program resulted in benefits in a few areas for participating children. The area most frequently showing benefits for the more-intensive group was motor development while socially appropriate behaviors most frequently showed benefits for the less-intensive group. There is also evidence the difference in motor skills translated into statistically significant differences in self-concept as measured by the child's perception of physical competence.

The subanalysis of severity by intensity of intervention sheds more light on the effects of the intervention for children with moderate and severe disabilities. All statistically significant differences for the severe children were positive and suggested that the five-day-per-week program benefitted the severe children in a variety of areas linked to child functioning. The most consistent evidence was for motor skills which favored the more-intensive intervention children whether measured by the BDI or Parent and Teacher SPECS. The more severe children also scored higher on the adaptive domain of the BDI, teacher SPECS cognitive and communication domains, and on the SIB's personal and community living skills at some reassessments. They also had higher perceptions of acceptance by their mothers and thought they had more physical competence. Recently, they perceived themselves as having more peer acceptance.

Children with relatively mild impairments who were in the less-intensive early intervention program scored higher on some cognitive and self-concept measures than their more-intensive intervention counterparts. There were very few areas, such as an isolated Teacher SPECS rating on motor skills, where the mildly impaired, more-intensive group children scored higher than those in the less-intensive group intervention.

For the family measures, there was less evidence of benefits associated with the more-intensive program. This is not surprising, since it was expected that there would be only indirect effects on family functioning.

The fact that the more-intensive program cost an additional $2,500 more per child (approximately 75% more) than the less-intensive program--for only moderate and fluctuating gains--raises additional questions. It is often suggested the initial investment in early intervention will more than be repaid in later years because fewer special education services will be needed. Given the data from the earliest years of these children's educational experience, such cost savings are not yet documented. However, severity analysis showed that more severely disabled children may gain greater benefits from the more intensive program. While this statement can not be made definitively, it bears further investigation and analysis.

In interpreting the results of this study, several points are important to keep in mind. First, this study was particularly well-done from a methodological perspective: children were randomly assigned to groups, there was extensive documentation regarding the comparability of those groups prior to the intervention, diagnosticians for most measures were uninformed about the purposes of the research or the group membership of children, there was extensive verification that the treatment was implemented as planned, contextual variables that might have contaminated the experimental design or affected the results were documented, and a broad set of child and family functioning measures were collected.

At the same time, the results from this study should not be accepted unconditionally or prematurely to make policy decisions. Instead, the results of this study need to be replicated before they are accepted as something more than sampling fluctuation. Such replications need to be done by independent investigators using similarly rigorous techniques.

Second, even though it is important to note that the alternative levels of intensity in this study were substantially different, perhaps they were not different enough. The one study in the literature sampling children who had disabilities which found substantial differences attributable to different levels of intensity was done by Lovass (1987) with a group of autistic children. In that study, the more intensive program consisted of 40 hours per week of one-on-one programming. In this study, the more intensive program consisted of 10 hours per week of primarily group programming. Thus, it is possible that a certain "threshold" of intensity must be achieved before benefits become apparent. However, it should be remembered that the levels of intensity investigated in this study are typical at the "upper-end" of intensities currently available to most program administrators given current resources. Thus, even though it is important to determine whether even higher levels of intensity would result in greater benefits, the feasibility of implementing those higher levels must be considered as research is designed.

Third, it is clear that the way in which intensity was defined in this study accounted for only a few of the many different variables which are included in the general construct of "intensity." Perhaps other ways of "intensifying" programs would have lead to different results. Those questions must be addressed. The results of this study should not be interpreted to suggest that the entire construct of intensity has been evaluated. Still, the variables of hours of engaged learning time per week, child:teacher ratios, and availability of one-on-one related services are among the most frequently noted dimensions when people discuss the construct of intensity.

Fourth, it is apparent that "sleeper effects" are possible, as shown by the Perceived Competence and Social Acceptance results at Reassessments #4 and #5. This study documents the importance of longitudinal research to more fully capture and explain observed differences in family and child functioning. The absence of child differences at Reassessment #2, especially on motor skills, makes apparent the importance of following the sample over long periods of time. The motor results are, after six reassessments, much more convincing than if the study had ended after the first or second assessment. Future data, especially measures such as the Perceived Competence and Social Acceptance that assesses self concept, are critical if these results are to be more clearly understood. The duration of these differences is important in assessing the efficacy of the intervention and can only be captured with longitudinal evaluation. Qualitative research may also lead us to different perspectives about the impact of early intervention on individual families and children.

As noted in the previous points, there are a number of good reasons why we should be cautious in concluding from these results that there will be little or no benefits for children and families if substantially more intensive early intervention programs are offered. It may be that the level of severity is an over-riding factor. As one study, this information makes an important contribution to our knowledge concerning the effects of more intensive early intervention programs, but it is only one study. More research is needed before we will adequately understand the relationship between intensity of intervention and progress made by participating children and families. The worst use of these results would be a simple-minded reaction which concludes that more intensive programs are not beneficial. Instead, these results strongly suggest the need for replication and systematic extensions in which different types of intensity on various disabilities at discrepant severities are tested and the "threshold" hypothesis is more closely examined.

Each year the federal government spends billions of dollars on early intervention programs for children who are disabled, disadvantaged or at-risk. State and local governments spend several times that amount. The results of this study suggest we should be cautious about assuming that more is necessarily better. More importantly, however, these results emphasize the need to immediately begin devoting substantial resources to conducting additional well-designed longitudinal research studies to determine what type of intervention programs are best for which children and their families. Because there will always be a finite amount of resources to fund early intervention, it is particularly important to evaluate the effects of those variables most closely related to costs. Intensity is one such issue. The results of this study add substantially to our knowledge about the effects of varying intensity, but much more research is needed.

SALT LAKE MEDICALLY FRAGILE AGE-AT-START STUDY

Project #5

COMPARISON: Grades I, II, III, and IV Intraventricular Hemorrhage Infants (IVH) --Services begun at 3 months adjusted age vs. services begun at 18 months adjusted age.

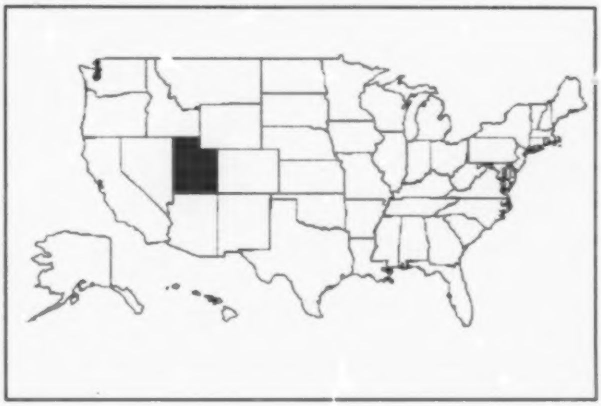
LOCAL CONTACT PERSONS: Gary Chan, University of Utah Medical Center; Jack Dolcourt, Primary Children's Medical Center

EIRI COORDINATOR: Glenna C. Boyce

LOCATION: Salt Lake City, Utah

DATE OF REPORT: October 1, 1994

Rationale for the Study



Early intervention specialists generally accept the premise that the earlier interventions are initiated with children who have, or are at risk for developing, disabilities, the greater will be the positive effects of those interventions. The basis for this premise is developmental theory, which indicates that early experience has a profound impact upon the development of young children. Early experience is seen as being even more critical for children with disabilities or who are preterm. These children are often less responsive and provide fewer readable cues (Rogers, 1988), and thus may interact differently with the environment and have fewer of the early experiences that promote optimal development.

Providing interventions as early as possible has been supported by other rationales. More time is available to impact deficits. There appears to be greater plasticity of the neural system when the infant is very young (Anastasiow, 1990). The social movement of the 1960s with the initiation of Head Start programs provided a model for initiating intervention for children prior to school age.

That this premise is well accepted by the early intervention community is evidenced by the fact that White, Bush, and Casto (1985-86) found it to be the second most frequently cited variable concomitant with early intervention effectiveness. Eighteen of the 24 reviewers discussing the age-at-start issue concluded that "earlier is better". Even the federal government, with the passage of Part H of P.L. 99-457, supported the concept that earlier is better.

In spite of this acceptance, Casto and Mastropieri (1986), through a meta-analysis of 74 studies of early intervention with children with disabilities from birth to five years of age, concluded that there was little evidence to support the premise that intervention given at younger ages resulted in greater benefits in child development than intervention given at older ages. Thus far, the empirical evidence in support of earlier age-at-start intervention is truly limited (Mastropieri, 1987), and the results have been confounded in studies with other variables (e.g.,intensity and duration of intervention). Direct comparison designs that isolate the effects of early vs later initiation of intervention with children with disabilities have not been located in the literature. Thus, while the age-at-start question is critically important to the developmental outcome of young children, it remains largely unresolved.

Medically fragile infants are a population who have much to gain from the resolution of this age-at-start question. These infants, who are usually characterized by inappropriately early gestational age, low or very low birthweight, and neonatal complications such as intraventricular hemorrhage or bronchopulmonary dysplasia, are at great risk for serious developmental delays and disabilities (Bennett, 1987; U.S. Congress, 1987). The number of these infants who survive the neonatal period has continually increased due to the advances in medicine (Bennett, 1987; U.S. Congress, 1987). The environment in the neonatal intensive care units, in which many infants live for as much as three months, is atypical of the early experiences most infants have (e.g., Rosenfield, 1980). These reasons make the investigation of the age-at-start question for the medically fragile population especially urgent. Therefore, this study compared the effects of intervention initiated "early" with the effects of intervention initiated "later" in the lives of medically fragile infants who had experienced intraventricular hemorrhage.

Review of Related Research

The present study is unique because it deals with two critical issues in early intervention. The first of these is often referred to as the age-at-start question. The second deals with the specific group of children used: medically fragile infants. Both of these issues will be reviewed in the following paragraphs.

Age-at-start of intervention. A number of prominent rationales have led the field of early intervention to endorse the premise that the earlier intervention is delivered the more effective it will be (Guralnick, 1991). This premise is founded on theories of child development, which assert that early experience, regardless of intervening experience, has lasting consequences for the child. For example, attachment theorists (e.g., Ainsworth, 1973; Sroufe, 1979) believe that vulnerabilities resulting from early experience result in later detrimental effects. Other theorists see intelligence as being modifiable, depending on the perceptual and motor experiences one has, particularly during the early years (Hunt, 1961). In fact, the early years are widely considered critical (a sensitive period) for the development of the central nervous system and of intellectual functioning in general (Bloom, 1964). During this time there appears to be great plasticity of the nervous system, and a lack of certain experiences are seen as being causally related to later adverse consequences (Anastasiow, 1990).

The rationale behind early intervention programs has been that if the first years of life are a significant period of development for typical children, then this period is even more critical for impacting the development of children who have or are at risk for developing disabilities. As was stated earlier, White, Bush, and Casto (1985-86) in their review of previous reviews of early intervention research found that the age for initiating intervention was the second most frequently cited concomitant variable associated with intervention effectiveness. Additionally, 18 of the 24 reviews that drew conclusions about the importance of the age-at-start asserted that "earlier is better". The federal government has also supported the premise that "earlier is better" with the passage of the Part H of P. L. 99-457. This legislation encouraged the development of intervention for children under age three who were "at risk" for developing disabilities.

Through a meta-analysis of 74 studies, Casto and Mastropieri (1986) attempted to compare the effects of intervention initiated at different ages, which they grouped as follows: 0-6 months, 6-18 months, 18-36 months, 36-48 months and 48-66 months. The results of their study did not reveal any advantage for those children who had received intervention at younger ages, and they concluded that thus far there is little empirical evidence supporting the assumption that intervention delivered earlier results in greater gains.

Another meta-analysis of 31 early intervention studies limited their sample to those in which children began intervention before three years of age (Shonkoff-Hauser-Cram, 1987). The mean effect of early intervention services was .62 standard deviation, indicating that children younger than three years of age benefited from early intervention services. (This effect size was only slightly greater than the effect size Casto and Mastropieri [1986] reported for children of similar ages.) They also reported a relationship between severity of disability and age at program entry. Infants with mild impairments were reported to have better developmental outcomes if they enrolled in treatment before 6 months of age, but no effect sizes were given.

The age-at-start issue is complex. Few, if any, studies have isolated the age-at-start issue from confounds and empirically compared the results of intervention initiated at two different ages (Mastropieri, 1987). The intensity and duration of intervention and the degree of the severity of the disability are concomitant variables that must be considered in any study investigating the age-at-start issue. Examining the importance of the age for beginning intervention through regression analysis, Mastropieri found that, with a sample of preschoolers with disabilities, pretest Bayley scores alone explained a significant proportion of the variance in development, but that starting age and length of treatment did not. Thus, while the age-at-start question is critical for the implementation of effective intervention, it remains basically unresolved.

Other issues also contribute to the complexity of the age-at-start issue. For example, the best age for intervention (indicating the correct sensitive period) may vary with disability type (Guralnick, 1991). Thus, the research conducted in this study directly responds to the age-at-start dilemma, while using a population that stands to benefit greatly from the results; (i.e., infants born at-risk for later developmental delays).

Medically Fragile Infants

Medically fragile infants (i.e., those with neonatal complications such as bronchopulmonary dysplasia, respiratory distress syndrome, and vision and hearing problems, as well as those with inappropriately early gestational ages and low birthweights) comprise a population for which the "age-at-start" issue is critical. These infants have atypical early experiences (i.e., premature birth and extended treatment in intensive care units), and they often develop serious disabilities (U.S. Congress, 1987; Bennett, 1987). Particularly vulnerable to later life problems are infants who experience intraventricular hemorrhage.

Intraventricular Hemorrhage (IVH). IVH is a condition in which blood seeps into the cerebral ventricles within the brain that secrete and convey cerebrospinal fluid. The hemorrhaging usually occurs within the first or second day after birth. The hemorrhages are graded from mild (I) to severe (IV). Most mild hemorrhages have no lasting effects (U.S. Congress, 1987). Approximately 40% of low birthweight infants (LBW) experience IVH (Bowerman, Donne, Silverman, & Joffe, 1984). IVH is one of the two most frequent causes of neonatal death (U. S. Congress, 1987). An estimated 50-60% of infants who suffer IVH survive (Volpe, 1981); however, information on the future developmental progress in this population is limited and controversial (Hynd et al., 1984). Sostek et al. (1987) found that although level of Grade I or II vs. Grade III or IV, IVH was not related to Bayley mental and motor scores at two years of age as a group, 40% of the children suffering IVH showed severe delays. At older ages, the findings are somewhat equivocal. For example, Williamson et al. (1982) found that 29% of IVH Grade I and II LBW infants exhibited moderate disabilities by the age of 3; whereas Papile et al. (1983) found that only 15% of such children could be diagnosed as having these disabilities. Both Papile et al. (1983) and Williamson et al. (1982) found that up to 80% of premature LBW survivors who experienced Grade III or IV IVH demonstrated moderate to severe disabilities by the third year of life. Bozynski et al. (1984) suggested that neonatal IVH typically resulted in motor rather than mental impairment, particularly in survivors of Grade IV hemorrhage.

Intervention Age-at-Start for Medically Fragile Infants

Recent early intervention literature has described various ages at which interventions with low birthweight infants began and has reported conflicting results. Reviews of this literature (Bennett, 1987; Casto et al., 1987; Ramey, 1984; Sandall, 1990) have continuously concluded that various types of interventions have been effective. However, most of the studies included in the reviews excluded children with neurological conditions such as IVH, and none addressed the issue of the age at which interventions should start. Resnick, Eyler, Nelson, Eitzman, and Bucciavelli (1987) did include infants with IVH and other complications and reported that a combination of in-hospital multi-modal intervention and home-based developmental intervention resulted in significant gains in child mental development when the children were assessed at 12 and 24 months.

More recently, the Infant Health and Development program (1990), a multi-site, randomized study, compared the effects of an intensive, educationally-focused, early intervention program for at-risk infants which included a family support and a pediatric follow-up component to a pediatric follow-up only program. Results of this study indicated that children who received the intensive early intervention performed the same as control group children during Year 1, but they performed better on cognitive and behavior problem measures at 24 and 36 months than children who received pediatric follow-up alone (Brooks-Gunn, Klebanov, Liaw, & Spiker, 1993). However, in infants with birthweights below 1,500 grams and IQ scores lower than 70, there were no treatment effects. In sum, the recent research findings regarding interventions begun early in life are still equivocal and support the need for further studies.

Based on this lack of conclusive data, it was deemed important to determine if interventions beginning early in life could prevent the development of later disabilities in medically fragile infants. Previous to this study, infants in Utah who had experienced IVH received only medical follow-up. This situation provided an opportunity to test an early versus later intervention hypothesis with two groups of IVH survivors.

Overview of Study

The purpose of this study was to investigate longitudinally the age-at-start intervention question with a sample of medically fragile infants all of whom experienced neonatal intraventricular hemorrhage. Subjects were recruited from the neonatal intensive care units of two tertiary care hospitals in Salt Lake City, Utah, between 1985 and 1988. To investigate whether intervention initiated "earlier" is better than intervention initiated "later," the infants were randomly assigned to either of two groups: one in which intervention was initiated when the infants were three months of age (i.e., corrected chronological age [CCA]),[1] and the other in which intervention was initiated when the infants were 18 months of age (CCA). These groups will be called the early intervention group and the delayed intervention group hereafter. The early intervention group began receiving individualized sensorimotor intervention from a physical therapist at three months CCA during which time the control group received no such intervention. The number of intervention sessions was determined individually according to the infants' needs with a minimum of one visit per month. During the pre-18 month period, both the early and delayed intervention groups had access to the standard medical treatment in the treatment area. This included neonatal care at the respective hospitals and referral to the Utah State Department of Health Neonatal Follow-Up Clinic or follow-up from private physicians. Funding for the NICU follow-up services was provided by the Utah State Department of Health, but those parents who accessed service from private physicians paid for the services themselves. Both groups were also free to access other services in the community, if they desired.

At 18 months (CCA) of age, both the early and delayed intervention groups began receiving individualized home-based intervention based on the Curriculum and Monitoring System (CAMS) (Casto, 1992). The intervention was given by the project early intervention educator. Sensory motor intervention was also provided to the children, if needed, by a physical therapist. Parents continued to be free to access other services. Intervention services via the project were discontinued in September, 1990.

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[1] *In other words, a child who is born 4 weeks prematurely would not reach a corrected age of 12 weeks until 16 weeks after birth.*

The timing of assessments was determined by age of child; initial assessments were performed at the age of 3 months (CCA). Some additional measures were completed at 6 and 12 months of age (CCA). Annual reassessments began at 18 months of age (CCA)[2] and continued until the present when some children are now receiving their 102-month reassessment. The measures used to identify possible effects from the alternate intervention treatments included multiple measures of child development, family support, family stress, and family functioning. Both the child and the parent (usually, but not always, the mother) participated in each reassessment.

Methods

This section presents the procedures for subject recruitment and assignment, the demographic characteristics of the groups, a description of the alternative intervention programs, a discussion of the treatment verification procedures, and cost analysis.

Subjects

A total of 58 subjects were enrolled between 1985 and 1988. All of these subjects had experienced neonatal intraventricular hemorrhages. Two subjects have since then died, but both participated in two or more reassessments. Initially, four other families agreed to participate in the study. One of these infants died before any assessments were completed, and one died soon after the initial assessments were completed; two withdrew from the study before the first reassessment. With these initial withdrawls, there were 28 and 30 infants in the delayed interventions and early intervention groups, respectively.

__Recruitment__. Infants qualified for participation in the study if they were patients in a Neonatal Intensive Care Unit (NICU) at either Primary Children's

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[2] *Use of the chronologically adjusted age was discontinued with the 42-month assessment. At this time, the assessment was timed according to the child's actual age, based on the date of birth.*

Hospital or University of Utah's Medical Center, if they experienced IVH, and if they resided in the catchment area for treatment. The catchment area included the Wasatch front and surrounding rural areas in Utah, Idaho, and Wyoming.

Assignment to groups. Subjects who met the inclusion criteria were identified upon discharge from the respective NICU. Parents of eligible infants were contacted via mail by the medical center in which the infant was a patient the month prior to reaching 3 months CCA. Infants who met the study criteria were considered for inclusion if the parents indicated a willingness to participate in either of the experimental conditions, depending upon where random assignment placed them. Prior to the random assignment, the infants were stratified on severity of hemorrhage and birthweight. Infants were then randomly assigned to the early intervention or delayed intervention conditions by a roll of a four-sided die. Parents were informed of their infant's assignment after they gave approval to participate in the study.

Demographic characteristics. Demographic information was gathered by questionnaires regarding family composition, parent education and occupation, family income, and ethnicity of the participating families. At the time the study began (infant age of 3 months [CCA]), the parents were mostly young (e.g., 60% of mothers were between 20 and 30 years of age), married, Caucasian couples. (In five families, either the father or the mother was Hispanic or Native American and in one family both parents were Hispanic.) For almost one-third of the families, this infant was their first child, and for another third, the infant in the study was their second child. In six families, the infant was a twin; in two cases, both twins are in the study; in two other cases, the child was the only surviving twin. Two infants were the only to survive from sets of triplets.

Most of the mothers and fathers had completed high school and some additional schooling. Sixty percent of the mothers were not working outside of the home. Approximately two-thirds of the fathers are blue collar or unskilled workers (Duncan

SEI category of 50 or less); about one-third of the families reported income of less than $20,000. English was the primary language spoken in all the homes.

Although random assignment was completed, initial differences between the early and delayed intervention groups were still a concern. Group comparisons on family demographic characteristics, mother pregnancy characteristics, and child medical characteristics are presented in Tables 5.1 and 5.2. Comparative analyses

Table 5.1

Comparability of Groups on Assessment Demographic Characteristics for Salt Lake City Medically Fragile Age-at-Start Study (for Total Sample)

	Delayed Intervention			Early Intervention				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Age of child in months at assessment	3.4	(.7)	28	3.3	(.5)	30	.45	-.14
• Age of mother in years	25.8	(4.4)	28	28.1	(5.6)	30	.10	.52
• Age of father in years	28.0	(5.1)	28	30.2	(5.8)	29	.13	.43
• Percent Male[*]	50.0		28	43.3		30	.62	-.12
• Years of education for mother[δ]	13.1	(2.3)	28	13.2	(2.0)	30	.87	.04
• Years of education for father[δ]	13.4	(2.3)	28	14.3	(2.1)	29	.09	.39
• Percent w/both parents living[**] at home	100		28	93.3		30	.17	-.24
• Percent of children who are[*] Caucasian	92.9		28	100		30	.16	.58
• Hours per week mother employed[δ]	9.6	(16.8)	28	10.2	(15.4)	30	.88	.04
• Hours per week father employed[δ]	42.3	(14.7)	25	41.9	(16.1)	26	.93	-.02
• Percent of mothers employed[*]	42.9		28	36.7		30	.64	-.12
• Percent of fathers employed as[*] technical/managerial or above	21.4		28	44.8		29	.06	.46
• Total household income[♣]	$24,179	($17,760)	28	$29,650	($17,307)	30	.24	.31
• % receiving public assistance[δ*]	28.6		28	23.3		30	.66	-.11
• % of children in daycare[δ*] more than 5 hours per week	35.7		28	24.1		29	.35	-.31
• Number of siblings[δ]	1.2	(1.0)	28	1.5	(1.7)	30	.38	.31
• % with English as primary[**] language	100		28	100		30	1.00	.00

Effect size is defined throughout this paper as the difference between the groups (early minus delayed ANCOVA scores, divided by the unadjusted standard deviation of the delayed intervention group (see Cohen, 1977; Glass, 1976; and Tallmadge, 1977 for a more general discussion of the concept of Effect Size).

[δ] Some reassessment information was used to arrive at these figures.

[*] Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scored "0."

[♣] Income data were categorical and were converted by using the midpoint of each interval into continuous data.

[**] At least one of the groups had no variance.

Table 5.2

Comparability of Groups on Mother Pregnancy and Child Hospital Characteristics for Salt Lake City Medically Fragile Age-at-Start Study (for Total Sample)

	Delayed Intervention			Early Intervention				
	$\bar{x}$	(SD)	n*	$\bar{x}$	(SD)	n	p Value	ES
• **Maternal Pregnancy Characteristics**								
Maternal Health Rating♦	2.6	(.6)	25	2.1	(1.0)	28	.30	-.83
Diabetes %*	7.1		28	10.0		30	.70	-.08
Bleeding at First Trimester %*	32.1		28	37.9		29	.65	-.11
Placenta Previa %*	0		28	3.3		30		-.13
Received 3 trimesters prenatal* care (%)	60.7		28	53.3		30	.58	-.15
No. of pregnancies	2.5	(1.3)	28	3.2	(2.4)	30	.19	|.54|
No. of previous aborted pregnancies (spontaneous/induced)	.4	(.7)	28	.7	(1.3)	30	.33	|.43|
No. pregnancies carried full-term	2.3	(1.1)	28	2.7	(1.7)	30	.29	|.36|
Mothers age at birth	25	(4.7)	28	26.4	(5.3)	30	.31	|.30|
Maternal Toxemia %*	0		28	0		30		.00
• **Neonatal Medical Risk Characteristics**								
Birthweight (grams)	1534	(681)	28	1302	(545)	30	.16	-.34
Grade of IVH* (% w/Grade III or IV)	39		28	30		30	.47	.18
Gestational Age (weeks)	30.8	(3.5)	28	29.4	(2.7)	30	.10	-.40
1-Minute Apgar	4.0	(2.5)	28	3.7	(2.4)	29	.63	-.12
5-Minute Apgar	6.1	(2.0)	28	6.2	(1.5)	29	.89	.05
Apnea (%)*	57		28	67		30	.46	-.18
Seizures (%)*	11		28	13		30	.77	-.06
Respiratory Distress Syndrome (%)*	7		28	13		30	.45	-.16
Bronchopulmonary Dysplasia (%)*	61		28	70		30	.47	-.18
Metabolic Acidosis (%)*	18		28	20		30	.84	-.04
Retinopathy of Prematurity*	25		28	33		30	.50	-.17
Hypertension (%)*	4		28	10		30	.34	-.18
No. of postnatal transfusions	8.2	(7.8)	28	10.6	(10.4)	30	.33	-.31
No. of days in NICU	26.1	(27.9)	28	35.5	(33.7)	29	.26	-.34
Medical Severity Index	17.0	(7.9)	28	17.8	(7.6)	30	.67	-.10

$$ES = \frac{\text{Early Intervention } \bar{x} - \text{Delayed Intervention } \bar{x}}{\text{Delayed Intervention SD}}$$

Except where absolute values are used, a more desirable outcome for the early group is indicated with a positive effect size.

♦ Maternal health is rated poor, fair, good categories (1-3) with higher scores showing better health.

* Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scored "0."

for the same variables are also presented for those subjects who have completed Reassessment #7 (at age 90 months) in Tables 5.3 and 5.4. Separate tables are included for Reassessment #7 subjects because with the smaller sample, differences in family, maternal, and infant hospital characteristics may be present.

Table 5.3

Comparability of Groups on Assessment Demographic Characteristics for those Subjects Included in 90-Month Analysis for Salt Lake City Medically Fragile Age-at-Start Study

	Delayed Intervention			Early Intervention				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Age of child in months at assessment	3.3	(.6)	19	3.3	(.6)	20	.94	.00
• Age of mother in years	25.8	(4.4)	19	28.5	(6.0)	20	.11	.61
• Age of father in years	27.1	(4.8)	19	31.4	(6.0)	19	.02	.90
• Percent Male[*]	42.1		19	40.0		20	.90	-.04
• Years of education for mother[δ]	13.2	(2.3)	19	13.1	(2.1)	20	.88	-.04
• Years of education for father[δ]	13.6	(2.3)	19	14.4	(2.2)	19	.32	.35
• Percent w/both parents living[**] at home	100		19	95.0		20	.06	-.17
• Hours per week mother employed[δ]	13.7	(19.1)	19	10.2	(15.1)	20	.52	-.18
• Hours per week father employed[δ]	45.3	(13.6)	16	44.7	(16.5)	17	.91	-.04
• Percent of mothers employed[*]	52.6		19	40.0		20	.44	-.23
• Percent of fathers employed as[*] technical/managerial or above	31.6		19	47.4		19	.33	.29
• Total household income[♦]	$28,684	($19,671)	19	$32,375	($18,450)	20	.55	.19
• % receiving public assistance[**]	26.3		19	20.0		20	.65	-.13
• % of children in daycare[**] more than 5 hours per week	42.1		19	31.6		19	.51	-.19
• Number of siblings[δ]	1.3	(.9)	19	1.7	(1.9)	20	.37	.44
• % with English as[**] as primary language	100		19	100		20	1.00	.00

$$ES = \frac{\text{Early Intervention } \bar{x} - \text{Delayed Intervention } \bar{x}}{\text{Delayed Intervention SD}}$$

For this table, the sign of ES indicates direction of difference only, no value judgement is intended.

[δ] Some reassessment information was used to arrive at these figures.

[*] Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scored "0."

[♦] Income data were categorical and were converted by using the midpoint of each interval into continuous data.

[*] At least one of the groups has no variance.

Table 5.4

Comparability of Groups on Mother Pregnancy and Child Hospital Characteristics for those Subjects Included in 90-Month Analysis for Salt Lake City Medically Fragile Age-at-Start Study

	Delayed Intervention			Early Intervention				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• **Mother Pregnancy Characteristics**								
Maternal Health Rating*	2.7	(.6)	17	2.2	(1.0)	19	.08	-.83
Diabetes (%)*	5.3		19	15.0		20	.33	-.25
Bleeding at First Trimester (%)*	42.1		19	42.1		19	1.00	.00
Drug Use**	23.5		17	47.4		19	.15	-.44
Received 3 trimesters of prenatal care	79.0		19	60.0		20	.15	-.45
No. of pregnancies	2.5	(1.2)	19	3.5	(2.7)	20	.18	|.83|
No. previous aborted pregnancies (spontaneous/induced)	.5	(.8)	19	.7	(1.5)	20	.66	|.25|
No. pregnancies carried full-term	2.3	(1.1)	19	2.9	(1.9)	20	.22	|.54|
Mothers age at birth	24.8	(4.5)	19	26.6	(5.5)	20	.28	|.40|
Maternal Toxemia (%)**	0		19	0		20		.00
• **Neonatal Medical Risk Characteristics**								
Birthweight (grams)	1552.6	(751.8)	19	1324.4	(557.7)	20	.29	-.30
Grade of IVH* (% w/Grade III or IV)	52.6		19	30.0		20	.16	.42
Gestational Age (weeks)	31.0	(3.9)	19	29.6	(3.0)	20	.20	-.36
1-Minute Apgar	4.2	(2.5)	19	4.0	(2.7)	19	.80	-.08
5-Minute Apgar	6.1	(2.2)	19	6.0	(1.6)	19	.93	-.05
Apnea (%)*	52.6		19	60.0		20	.65	-.13
Seizures (%)*	15.8		19	20.0		20	.74	-.09
Respiratory Distress Syndrome (%)*	5.3		19	15.0		20	.33	-.75
Bronchopulmonary Dysplasia (%)*	57.9		19	70.0		20	.44	-.22
Metabolic Acidosis (%)**	0		19	10.0		20	.18	-.30
Retinopathy of Prematurity*	31.6		19	30.0		20	.92	.03
Hypertension (%)**	0		19	5.0		20	.35	-.17
No. of postnatal transfusions	9.3	(8.7)	19	12.1	(11.4)	20	.40	-.32
No. of days in NICU	29.4	(30.7)	19	42.3	(33.1)	20	.22	- 42
Medical Severity Index	17.1	(8.3)	19	17.3	(8.1)	20	.94	-.02

$$ES = \frac{\text{Early Intervention } \bar{x} - \text{Delayed Intervention } \bar{x}}{\text{Delayed Intervention SD}}$$

Except where absolute values are used, a more desirable outcome for the early group is indicated with a positive effect size.

* Maternal health is rated poor, fair, good categories (1-3) with higher scores showing better health.

* Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scored "0."

** At least one of the groups has no variance.

Analysis of family demographic characteristics (Table 5.1) indicated that of the 17 variables on which comparisons were made, using a significance level of .10, there was a statistically significant difference between the groups for three variables, including mother's age, father's education level, and percent of fathers employed as technical managerial or above. These three variables, as well as all other demographic, pregnancy, and birth variables, were considered as possible covariates (see discussion entitled "Selection of Covariates" in the Results section). Given the many variables on which comparisons were made, it is not surprising that there were statistically significant differences on several variables. When the data are considered in total, it appears that the groups were very comparable in terms of demographics.

Information concerning the mother's pregnancies was provided by the hospitals. About half of the mothers were rated as being in poor or fair health. For approximately 30% of the group, this was their first pregnancy, and another 33% had previous aborted pregnancies (spontaneous or induced). Most of the mothers were in their 20s, but 7 were 19 or under, and 15 were 30 or older. There were no statistically significant differences between the groups on pregnancy characteristics (refer to Table 5.2).

The medical information for the children was supplied by the hospital via the discharge summaries. The gestational age of the children ranged from 24 to 40 weeks, with only 4 infants reaching a gestationally appropriate age. The children ranged in birthweight from 530 g to 3636 g, with the median weight being 1225 g (i.e., a little under 3 pounds). Five infants weighed more than 2500 g, which is the commonly accepted marker for low birthweight infants. About one-third of the children's IVH conditions were classified as more serious (grade III or IV). The days spent in the newborn intensive care unit ranged from 0 (for three of the children) to over 90 days (for another three children), with the median length of stay being 27 days. All but three of the children received at least one blood transfusion, and three received over 30 transfusions. The median number of transfusions was seven.

Most studies of medically fragile children are limited to low or very low birthweight and early gestational age. Given that five subjects had birthweights (BWT) which would not be considered low (i.e., over 2500 g) and three had a gestational age (GA) which would not be considered early (i.e., over 36 weeks), two sets of additional analyses were completed. In one analysis, those with birthweights over 2500 g were eliminated, and in the other analysis those with a gestational age over 36 weeks were eliminated. With these deletions, the developmental scores of the early and delayed groups were compared for the initial assessment and the first five reassessments. These findings did not differ from the comparisons involving all 58 children. Therefore, the decision was made to include all 58 infants in all subsequent analyses.

When the hospital characteristics of the two groups were compared, the delayed intervention group had "better" average scores on most of the medical characteristics than the early intervention group. The negative sign of the effect sizes in Table 5.2 indicates this. However, only the difference on gestational age was statistically significant, and most of the effect sizes demonstrate a difference of less than a third of a standard deviation between the groups. The differences between the groups on several other medical characteristics (e.g., days in intensive care, birthweight, number of transfusions), even though not statistically significantly different, were thought to be important and were therefore considered as covariates in subsequent analyses.

The comparison of demographic, mother pregnancy, and child characteristics for those tested thus far at the 90-month reassessment (#7) (shown in Tables 5.3 and 5.4) demonstrated that these two limited groups were also very comparable. Approximately the same differences that existed in the total sample exist in this group of 39 families.

Presently, most of the families still reside in the urban areas of the Wasatch Front (75%). Thirteen percent live in surrounding rural areas of Utah, Idaho, or Wyoming. Twelve percent live further away, with two subjects living in California, and one living in Ohio, Arizona, Connecticut, and Washington, respectively. Some changes in demographic characteristics occurred over time. For example, when the children were 5½ years old (the most recent reassessment with all the children tested), 83% were living in homes with two parents. This percent is lower than the 97% at the initial assessment. Families had an average of three children. More mothers were working outside the home, but 48% (contrasted with 60% at the initial assessment) of them still reported no employment. Over half of the fathers' occupations were classified as blue collar or unskilled, but the percent reporting such was less (53% instead of 67%).

Subject attrition. Four subjects did not stay with the project until the first reassessment. One died before the initial assessment was completed. The initial developmental, medical, and demographic assessment data of the other three were compared to the data of the 58 subjects in the study with t-tests. The infant data (number of days in intensive care and infant development total score) indicated that these infants who did not stay with the study were no different than those who remained in the study. However, the demographic data (i.e., income and father's occupation) showed that these three families were similar to the families in the study who were at the lower end of the SES continuum. Having these three subjects out of the study may limit the generalizeability of the findings slightly, but given the socioeconomic diversity among the 58 families in the study, we feel that the effect of the loss of these three is minimal.

To minimize attrition, the interveners and site coordinator in this project maintained updated telephone numbers and addresses for the participants. Data were collected in person or by mail approximately every 6 months for the child's first 18 months and monthly contacts were attempted after 18 months, so there was frequent contact with the families. For several years, a semiannual newsletter kept parents informed of the study. Since then, Christmas cards, birthday cards, and reports of the annual assessments have been sent to the families in order to keep the families involved and the addresses updated. Arrangements were also made to provide intervention services and assessment for those participants who moved to other states.

Despite the efforts to minimize attrition, a few children were lost from the study. Annual assessments have been completed for Reassessments 1 through 5. At the first reassessment (18 months CCA), all 58 children participated in the testing; at Reassessment #2 (30 months CCA), 57 participated; at Reassessment #3 (42 months), 57 children participated; at Reassessment #4 (54 months) 54 participated; and at Reassessment #5, 55 participated. The subsequent reassessment cohorts are not complete; thus far, 49 and 40 have completed Reassessment #6 (78 months) and Reassessment #7 (90 months), respectively. Some children have missed one or more assessments. One subject has only been assessed twice (at Reassessments #1 and #3). Since then, the mother refuses to be contacted. Two subjects died (one after Reassessment #2 and one after Reassessment #4). The scores of the two that have died were among the lowest 10% on the initial assessment BDI total score; one was from the early and one from the delayed intervention groups, respectively. Two additional children missed the fourth reassessment and one missed the sixth reassessment for various reasons. We do not think the outcomes have been affected by these very low levels of non-participation.

Intervention Programs

The intervention was conducted in two phases for this project. The first phase provided sensorimotor intervention to the early intervention (experimental) group beginning at 3 months CCA, while the delayed intervention (control) group received the current level of community service (referral to the NICU follow-up clinic or assistance from their physician). The second phase, delayed intervention, was received by all infants in both groups. Delayed intervention began when the infants reached 18 months CCA and consisted of individualized home-based intervention services based on the Curriculum and Monitoring System (CAMS), and sensory motor intervention provided if needed by a physical therapist. A tabular summary of the alternate intervention in treatments is presented in Table 5.5.

Table 5.5

Treatments

Early Group	Delayed Group
3-18 Months	
• Sensorimotor Evaluation by PT or OT	
• Home or center visits by PT, 1 or 2 per month*	
• Treatment flexible but focused on sensorimotor development	
• Availability of neonatal care at hospitals	• Availability of neonatal care at hospitals
• Referral to State Department of Health Neonatal Follow-up Clinic	• Referral to State Department of Health Follow-up Clinic
• Availability of follow-up with physician	• Availability of follow-up with physician
18 Months + (Both Groups)	
• Home visits (1 per month) by Early Childhood Special Educator^	
• Visitor modeled and taught mother developmentally appropriate^ behaviors with child and set goals	
• Motor intervention provided by PT or OT, as needed	

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* Flexible schedule, depended on needs of infant ($\bar{x}$ visits = 17, range = 1-36)

Flexible schedule, depended on needs of children during the time. During the time of the study, P.L. 99-457 was implemented. Thus, services were provided either by the study's early childhood special educator, or arrangements were made to place child in other ongoing programs.

Services during 3 to 18 month age period. Medical services after leaving the hospital were available to all the infants. The infants were referred to the Utah State Department of Health Neonatal Follow-up Clinic. This was standard treatment in the state at that time. These services were funded by the State Department of Health. Families were also free to access other medical or intervention services. Use of these services was monitored. Approximately four, families used the services of the Neonatal Follow-up Clinic. Hours of services provided by other intervention agencies were tracked and are discussed later in the Treatment Verification section. These services are the only services the delayed intervention group received until the children were 18 months of age (CCA).

Additional services were provided by the project to the infants in the early intervention group. At three months CCA, they were evaluated by a licensed physical or occupational therapist for an initial sensorimotor evaluation using the CAMS Motor Placement Test. At that time, scheduling and programming were discussed with the family. Frequency of intervention was determined by CAMS test scores, the type and quality of the infant's movement patterns, and the amount of interactive time the parents had available. Most infants were seen once or twice per month during the first few months when movement patterns were limited. The treatment schedule was flexible so that weekly visits were scheduled if abnormal patterns or tone were noted, or if significant delays persisted. However, if normal development with good quality of movement was occurring, intervention was limited to monthly visits. Generally, infants who received more visits were perceived by the physical therapist as needing more intervention. Similar levels of early intervention program intensity for low birthweight infants have been described by Resnick et al. (1987; 1988), Raugh et al. (1988), Field et al. (1980), Nurcomb et al. (1984), and Piper et al. (1986).

Treatments consisted of individualized activities designed to encourage appropriate movement patterns in a normal developmental sequence. The activities were updated constantly to accommodate progress and were designed to be integrated into daily family routines. Parents were present during treatment sessions which lasted approximately 45 minutes and included a review of progress on treatment goals, direct therapy, and an opportunity for the parent to work with the child. Parents were provided with written and illustrated home program activities. Parents were asked to work with the child at home at least 20 minutes per day, five days per week, on techniques they had learned in the intervention sessions.

Attendance and progress were monitored on an ongoing basis by the site coordinator by reviewing the therapist's progress notes. The CAMS placement test checklist was updated as goals were met. If a child required other equipment or services, the physical therapist referred the family to agencies in the Salt Lake City area or attempted to obtain equipment no longer being used by other children. The physical therapist also maintained a supply of equipment which she provided to subjects at no-cost. If a child moved out of state, intervention, if needed, was arranged with local therapists by the project coordinator and was paid for by the research project. Progress was monitored by phone calls with family and/or reports from physical therapists.

Services initiated at 18 months. At eighteen months corrected age, the infants in the delayed intervention group, as well as those in the early intervention group, received intervention services. The Curriculum and Monitoring Systems (CAMS) (Casto, 1979) provided the curriculum and format for the intervention. CAMS was designed to meet the educational needs of young children with disabilities served by the Multi-Agency Project for Preschoolers (MAPPS). The project collected data attesting to the efficacy of the program and was validated in 1980 (and revalidated in 1985 and 1992) as an exemplary program for national dissemination by the Joint Dissemination Review Panel (JDRP) of the U. S. Department of Education. MAPPS is one of only 21 early intervention projects validated by the JDRP. MAPPS is also a National Diffusion Network (NDN) program and has been used nationwide.

Each of the CAMS programs is printed in an easy-to-use block style design and bound in a notebook. This format was selected to allow persons administering the program to photocopy individual pages for use by the parents or trainers working directly with the children. With training, CAMS can be used by parents, teachers, and paraprofessionals in the home or in an institutional/school setting. The five CAMS programs are: (a) receptive language, (b) expressive language, (c) motor development, (d) self-help skills, and (e) social-emotional development.

The **Receptive Language Program** teaches the student skills that do not require verbalization but are necessary in the understanding of oral language. Skills include identifying objects, following commands, and touching body parts.

The **Expressive Language Program** teaches children general speaking skills, beginning with the formation of sounds and proceeding through the development of simple grammatical sentences. It focuses on language-building and articulation.

The **Motor Program** is designed to teach gross and fine motor skills. The program stimulates normal motor development, beginning with raising the head and proceeding through running, hopping, and drawing shapes. This program is intended for children with mild to moderate impairments.

The **Self-Help Program** is designed to teach basic skills for self-care. Included in the curriculum are feeding, dressing, personal hygiene, and toileting skills.

The **Social-Emotional Program** is designed to teach basic social-emotional skills, including both child-adult and peer interactions.

All infants and their families were visited by a developmental specialist, and those infants who needed physical therapy services received them from a physical or occupational therapist. For example, if a child in the delayed intervention group was identified by the placement test as having a motor delay, she/he received motor intervention from the physical therapist following the CAMS program. Those children in the early intervention group who still required motor services continued meeting with the physical therapist. If a child who received motor services in the early intervention group no longer required those services, the services from the physical therapist were terminated and only the services from the child development specialist were given. The physical therapist followed the same procedures outlined in the early intervention service section. For those children living out of state, the site coordinator arranged for intervention services with local agencies when needed and possible, and children were monitored through phone calls to parents and reports from these service providers.

The interventions delivered by the developmental specialist were primarily delivered via home visits. Physical therapy was usually provided in a clinic, but either type of intervention was provided where it was most convenient for the parent.

At 18 months (CCA) of age, all infants were assessed with the CAMS assessment. The individual intervention goals selected jointly by the developmental specialist and the mother were based on the CAMS (Casto, 1979) assessment and parent concerns.

The child development specialist usually met with the parent and child once per month. The frequency of the intervention sessions with the physical therapist were based on the needs of the infant and family. Some professionals question whether the one-time-per-month service is of sufficient quantity. Although some home-based early intervention programs are more intensive than one-time-per-month, a survey of Roberts and Wasik (1990) of 643 home-based early intervention programs demonstrated that the one-time-per-month visit was the most typical service delivery option. Hence, this program is consistent with typical practice. The frequency of visits by the developmental specialist was reevaluated annually when the children were 30, 42, and 54 months of age.

A typical intervention session was 45-60 minutes in duration. Each session began by asking how the child was doing and followed up on any problems (medical, family, etc.) discussed at the last visit. Then, using CAMS, the intervener assessed the child's progress on the items suggested for home activities in the previous session. If the child passed these items, new activities were suggested and demonstrated. Following the assessment, the intervener and child played with selected toys designed to teach age-appropriate skills (shape sorters, bead stringing, puzzles, etc.). Before the session ended, the intervener wrote down the suggested activities, gave examples showing how to teach these activities, provided appropriate toys if necessary, and answered any questions the parent had.

For example, if the objective for a child was to point out facial features, the child development specialist taught the parent an exercise to teach the child facial features. When the next meeting occurred, the child development specialist asked the child to point out facial features. If the child showed competence in that area, a new objective was established. Some children had objectives in several domains, while others had only one. The child development specialist provided recommendations to parents regarding problems or concerns such as toileting or behavior.

The parent was asked to spend 20 minutes each day, 5 days each week, providing similar intervention with their child at home. The child development specialist talked with the parent via telephone at least once between clinic appointments to check on progress and answer questions.

Midway in the study, the focus of service provision changed slightly as appropriate community services became more available to young children with disabilities. In compliance with P.L. 99-457, the Utah Departments of Health and Education developed more early intervention and education programs to meet the special needs of these children. While children in the study continued to receive the interventions as previously described, parents were assisted in accessing community services when their children entered the delayed intervention phase. Children received both public and private preschool services, occupational, physical, and speech/language therapies, and services to the hearing and visually impaired.

In sum, all children were involved in individualized intervention services at 18 months CCA and thereafter. The frequency of the intervention varied.

With the ending of the funding for initial grant (September 1, 1990), the intervention provided by the project ceased. Although the intervention portion of the project was finished, the site coordinator continued to attempt to find community programs for families, when requested to do so by the family. With the intervention portion of the study being over but the research portion continuing, it seems appropriate to describe the sample's intervention or education program at that time.

At the time services from the STET Project ended, parents were contacted by phone to ascertain what other services were being used. Fourteen children were attending kindergarten; two were involved with special education programs. The one attending the Utah School for the Deaf was from the control group, the other attending a program for children who had experienced IVH, was from the experimental group. Of the 16 children in preschool, one child from the control group, two children from the experimental group were attending special education preschool programs. Time spent in these programs averaged 35 hours each week during the school year. One child (in the early intervention group) attended a Head Start program, which ran for 35 hours each week during the school year. Weekly speech therapy sessions were received by six children from the control group (the average weekly time being one hour and 10 minutes) and two children from the experimental group (the average weekly time being three hours.) Physical therapy was received by three of the control subjects (averaging 1½ hours each week), and seven of the experimental subjects (averaging two hours each week.) The services received by the groups appear comparable.

Treatment Verification

In order to decide if an intervention is beneficial, it is extremely important to know whether the treatment was implemented as expected. Therefore, a number of procedures were implemented to verify that treatment was implemented as intended. Table 5.6 reports treatment verification data. Records were kept reporting the number of sessions of interventions provided by the project developmental specialist, the physical therapist, and the out-of-state service providers. Some parents also obtained other services for their children in the community. These services were

Table 5.6

Treatment Verification Data for the Salt Lake City Medically Fragile Age at Start Study

	Delayed Intervention			Early Intervention				
	x̄	(SD)	n	x̄	(SD)	n	p Value	ES
3-18 MONTH Reassessment #1								
• No. of early intervention sessions[b,c]	-----		28	17.2	(10.3)	30	---	---
• Additional Services[$]								
Hours of speech therapy	.4	(1.9)	28/2◆	1.0	(3.4)	30/6◆	.38	.32
Hours of physical therapy	22.9	(63.9)	28/8	12.7	(44.2)	30/8	.48	-.16
Daycare	76.1	(267.5)	28/4	158.5	(407.2)	30/9	.37	.31
Preschool	0	(0.0)	28/0	0	(0.0)	30/0	---	---
• Parent rating of satisfaction[a,c] with program	-----		28	3.9	(.3)	25	---	---
19-30 MONTH Reassessment #2								
• No. of early intervention sessions[b]	11.6	(18.0)	28	12.1	(13.1)	29	.95	.03
• Additional Services[$]								
Hours of speech therapy	1.1	(4.0)	27/3◆	.1	(.4)	29/1◆	.18	-.25
Hours of physical therapy	24.0	(79.5)	27/6	5.1	(12.7)	29/6	.23	-.24
Daycare	199.3	(417.6)	27/7	279.7	(523.3)	29/9	.53	.19
School	34.8	(93.4)	27/4	35.1	(148.7)	29/5	.99	.00
• Parent rating of satisfaction[a] with program	3.7	(.5)	16	3.8	(.4)	14	.56	.20
31-42 MONTHS Reassessment #3								
• No. of early intervention sessions[b]	4.3	(5.9)	26	7.0	(9.8)	26	.24	.46
• Additional Services[$]								
Hours of speech therapy	5.8	(18.1)	26/4◆	6.1	(20.4)	28/3◆	.95	.02
Hours of physical therapy	7.6	(24.6)	26/5	5.0	(16.2)	28/3	.65	-.11
Daycare	255.2	(560.0)	26/8	325.7	(580.6)	28/9	.65	.13
School	105.2	(153.4)	26/13	83.1	(247.5)	28/7	.70	-.14
• Parent rating of satisfaction[a] with program	3.5	(.8)	18	3.7	(.5)	19	.28	.25

$$\text{ES} = \frac{\text{Early Intervention } \bar{x} - \text{Delayed Intervention } \bar{x}}{\text{Delayed Intervention SD}}$$

(continued)

[a] Parents involved in each alternative type of intervention rated their satisfaction with the program on a four-point scale (4 = excellent, 3 = good, 2 = fair, 1 = poor) in response to seven questions, the response to overall satisfaction is reported here.

[$] Information about therapeutic services received by the child in addition to the regular early intervention program (e.g., daycare, preschool, physical therapy) was obtained via a parental questionnaire.

[c] Infants and families in the Delayed Intervention group received 0 early intervention services from the SLC/IVH project prior to 18 months of age; therefore, total intervention sessions received and parent rating of satisfaction are not reported.

[b] These services included sessions with a physical therapist or an early childhood specialist, except that prior to 18 months of age (Reassessment #1) only sensory motor intervention was provided.

◆ Few families accessed additional services; hence, the number of families reporting a particular service is included along with the number who completed the survey (e.g., 28/2 indicates that 28 parents completed the form, but only 2 reported that particular service).

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Table 5.6 (continued)

Treatment Verification Data for the Salt Lake City Medically Fragile Age at Start Study

	All Subjects Included in Analyses							
	Delayed Intervention			Early Intervention				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
43-54 MONTH Reassessment #4								
• No. of early intervention sessions'	4.2	(8.4)	26	8.2	(21.5)	25	.39	.48
• Additional Services'								
Hours of speech therapy	11.1	(28.1)	24/6'	3.1	(15.9)	26/1'	.22	-.28
Hours of physical therapy	11.4	(31.0)	24/5	5.6	(18.1)	26/3	.42	-.19
Daycare	109.3	(409.3)	24/5	294.9	(527.1)	26/8	.17	.45
School	305.9	(360.7)	24/18	379.0	(801.2)	26/14	.68	.20
55-66 MONTH REASSESSMENT #5								
• No. of early intervention sessions'	4.3	(6.7)	12	8.2	(19.3)	10	.56	.58
• Additional Services'								
Hours of speech therapy	7.0	(14.7)	22/5'	1.8	(8.5)	22/1'	.17	-.35
Hours of physical therapy	8.7	(30.4)	22/2	15.9	(41.4)	22/4	.52	.24
Daycare	501.8	(744.6)	22/9	59.1	(196.8)	22/2	.01	-.59
School	312.9	(299.8)	22/6	433.5	(576.3)	22/16	.39	.40
55-66 MONTH REASSESSMENT #6								
• Additional Services'								
Hours of speech therapy	19.7	(55.4)	25/5'	2.1	(10.0)	23/1'	.13	-.32
Hours of physical therapy	18.2	(50.1)	25/5	10.4	(40.8)	23/2	.56	-.16
School	758.6	(370.6)	25/24	930.8	(297.4)	23/23	.08	.46
Other services total hours	1.7	(7.8)	25/2	.9	(2.9)	23/2	.63	-.10

also monitored on a yearly basis by parents completing an Additional Services form. Program Satisfaction Questionnaires completed by parents during the first years of the project provided another type of verification data.

Intervention sessions provided by project. Both home visits and clinic visits were recorded in the subject's file. These were summed together and appear on Table 5.6 under "number of intervention sessions provided by project." Regular phone contacts were also made with subjects (with the early intervention group during the first 15 months of the project), monitoring progress, making appointments, and checking on services, if subjects lived out of the area. Records of these phone contacts with parents were recorded in the interventionist's notes. Analyses of these records indicated that subjects who were living out of the area and/or who had some special treatment considerations were personally contacted an average of 6.8 times prior to Reassessment #1, 3.8 times between Reassessment #1 and #2, 4.2 times between Reassessment #2 and #3, and 5.4 times between Reassessment #3 and #4. Thus, efforts were made to maintain accurate progress notes on all subjects, regardless of geographical location or extenuating circumstance.

The mean number of intervention sessions during the 3- to 18-month age period for the early intervention group was 17.2 (SD = 10.2), with the number of sessions ranging from 1 to 36. In order to delineate the differences in number of intervention sessions across the group, the frequency data for the intervention sessions of the children in the early intervention group is presented in tabular form (see Table 5.7). Three children received less than 5 visits, and an additional 11 received less than 15 visits, which would have been the number if each child had been visited monthly as planned. Forty percent of the children received 20 or more visits. The problems associated with providing optimal frequency of intervention will be discussed at the end of this section. For the children who received 30 or more sessions with the project therapists, the therapist's notes portray children who had severe problems.

Table 5.7

Frequency of Intervention Service Visits for the Early Intervention Groups Ages 3 to 18 Months for the Salt Lake City Medically Fragile Age-at-Start Study

	Frequency	Percent	Cumulative %
Less than 5 visits	3	10.0	10.0
5 to 9 visits	6	20.0	30.0
10 to 14 visits	5	16.7	46.7
15 to 19 visits	4	13.3	60.0
20 to 24 visits	3	10.0	73.3
25 to 29 visits	5	16.5	86.7
30 and more visits	4	13.3	100.0
TOTAL	30	100.0	

For Reassessments #2, #3, #4, and #5, the intervention received directly through the project, and additional intervention arranged by the project or parents are reported on Table 5.6. The children in the early intervention group consistently received more intervention through the project than did the delayed intervention group, but the differences are not statistically significant. However, when the total number of services for reassessments #2 through #5 were analyzed with a t-test, the differences between the delayed and early intervention group were not statistically significant.

The only time then that the number of services received by the two groups was statistically significantly different was at the eighteen month reassessment when it would be expected. If, however, families in the delayed intervention group accessed services on their own during this time, then there may not have been differences in services received.

An analysis of this intervention participation data demonstrates that often neither the physical therapist nor the developmental specialist were able to provide the optimal number of intervention visits. For example, Table 5.7 indicates that 21 of the 30 infants in the early intervention group received 10 or more visits, which approximated the suggested minimal number of monthly visits. Between the ages of 18 and 30 months, monthly visits were still encouraged; however, fewer visits were appropriate if the child was receiving other intervention. After that time, the frequency of visits was decided on a case by case basis, with fewer than monthly visits sometimes being recommended. The decreasing number of visits is partly explained by the annual re-evaluation of the "appropriate or needed" number of visits. However, parents often missed appointments. Notations were kept by the physical therapist or the developmental specialist for each visit completed, each visit attempted, and each visit scheduled. Many problems in the families' lives (e.g., child or mother illness, changes in jobs, transportation, marital and financial problems) were cited. The number of cancelled or missed appointments was high. For example, the notations for one subject listed two completed intervention sessions versus 10 no shows. Several examples indicate the range of reasons for low participation. One mother agreed to participate in the assessments, but not in the intervention sessions. She felt that it would make her child consider herself disabled. In another family, the child in the study was the least disabled of the three children. The mother did not have time to participate because of all that she had to do with her other children. Finally, many parents in the sample did not think their children needed intervention, they felt they were doing fine, considering they were "young" for their age group, and they felt that the children would grow out of any delay. Finally, children who lived in rural areas or moved from the catchment area typically did not receive intervention unless the parent perceived a significant need for such services.

Additional services. Annually, parents completed a survey reporting additional services the child had received for the previous year. These additional services included speech therapy, physical and occupational therapy, daycare, and preschool. The project director and/or home visitor sometimes helped families access other services as these services became available in the communities and families found services on their own. These services are recorded as additional services. Across reassessments, the majority of families did not access any type of additional services. For example, less than 25% of the sample reported accessing speech therapy or physical therapy at any given reassessment. To indicate the numbers who did access services, the number who did participate in the various categories are noted in Table 5.6. Under column "n," for example, 28/3 indicates that 3 of the 28 subjects accessed that particular service. In addition to the average scores reported in Table 5.6, medians were computed for the speech therapy, physical therapy, and preschool at Reassessments #1, #2, #3, and #4. All the medians were 0, again indicating that most of the children in the two groups did not receive additional services.

The average number of additional services accessed by two groups were compared. Table 5.6 shows that the delayed intervention group usually received more speech and physical intervention and school through other services than the early intervention group, but the differences did not reach the .10 level of statistical significance. The difference at Reassessment #1 is of particular importance because if the delayed intervention group accessed enough other interventions before the 18-month reassessment, there would be little treatment difference between groups. Although there was great variability within each group in terms of number of hours of services received, there were not significant differences in the average number of additional services accessed.

The physical therapy services accessed in particular would be quite similar to the services provided by the project physical therapist. Therefore, we examined the number of physical therapy hours reported on the Additional Services Form. Eight mothers in each intervention group reported accessing physical therapy outside of the project. Two of these (one from each of the intervention groups) reported 240 and 320 hours. The others reported from 1 to 84 hours. We added the physical therapy hours to the number of early intervention sessions, reasoning that sessions usually lasted one hour. The two cases with the large number of hours were excluded from the analysis because that many hours of physical therapy in 15 months is highly unlikely, and therefore, their accuracy of reporting was questioned. The number of hours of services (early intervention services provided by the project plus other physical therapy hours) received by the two groups were compared with a t-test. The differences between the groups was statistically significant (p = .09, ES = .38). The infants in the early intervention group received more services.

Parent satisfaction with program. Another aspect of treatment verification is whether the parents were satisfied with the intervention services delivered by the program. Annually, parents were requested to complete a questionnaire regarding their satisfaction with the intervention services delivered by this program. The questionnaire consisted of seven program qualities that were rated on a scale of 1-4, with 4 being the most favorable rating. The final item requested a rating of parent satisfaction with the program in general. At Reassessment #1, the early intervention group's mean rating of satisfaction with the program was 3.9, indicating very favorable satisfaction (see Table 5.6). At later reassessments, parents in both the early and delayed intervention groups consistently rated the intervention favorably.

Site review. Formal site reviews were conducted during each year of the project as part of the treatment verification process with the last formal site review being completed on August 17, 1990. Those participating in the site review included the site coordinator, physical therapist, and two child development specialists. The purpose of the site reviews was to collect information about the nature and quality of early intervention services that were delivered to verify that the research conducted by EIRI was implemented as intended, and to collect needs assessment data which would be useful to site administrators.

The site review process, as described in the Treatment Verification Handbook for Research Sites (EIRI, 1988), was implemented according to the general procedures described in the Guide for Site Reviews of EIRI Research Sites. The site review took place at K2D2, the facility where most sensorimotor and CAMS interventions were delivered and included a review of eight randomly-selected subject records, observations of one sensorimotor and one CAMS intervention session, interviews with interveners, and inspection of the facility.

The review team found that there were substantial differences in the services provided to the two groups prior to 18 months. Intervention services judged to be of high-quality were provided to the early intervention group prior to 18 months CCA and to both groups after 18 months CCA. Assessment procedures were carried out regularly, appropriate plans and records documenting interventions and child progress were in place. It was found that several of the older subjects in the study were working on the final objectives in the CAMS curriculum.

Contextual Variables

Other events transpired in the lives of the families during the intervention that research has shown can influence child development or family functioning. It is important to know if these events, hereafter designated as contextual factors, differed between the two groups because these factors might have influenced the child and family outcomes being measured.

Family demographic variables, reports of family resources, family functioning and stressful life events, child health, and the intervener's rating of the parent's participation in the intervention, were the contextual factors analyzed. Demographic data that were subject to change, including family composition, hours mother works outside of the home, total income, and percent receiving public assistance were collected at each reassessment. As can be seen in Table 5.8, the groups appear very comparable on the demographic factors and the reports of family stressors, resources, adaptability, and cohesion across reassessments. The only statistically significant differences are for adaptability at Reassessment #4, and the family stress score at Reassessment #6. Two statistically significant differences in over 80 comparisons are likely to be the result of random fluctuation. There were also statistically significant differences on child health and ratings of parent participation. These will be discussed next.

Parents also completed a Child Health Survey at each reassessment. The item rating the child's general health (reported in Table 5.8) is rated from 1 (health condition worse than other children) to 3 (health condition better than other children). Group means range from 1.7 to 2.2, indicating average health. At the 30-month and 42-month reassessment there were statistically significant differences with the children's health being rated higher for the early intervention group than it was for the delayed intervention group; while at the 18-, 54-, 66-, 78-, and 90-month reassessments there were no statistically significant differences between the health ratings of the two groups.

Interveners' ratings of the parents' support of, involvement with, and knowledge of their child's condition and program at the 1st three reassessments are also reported in Table 5.8. The parent qualities were rated on a scale of 1-3, where 3 represented the most favorable rating. Mean scores ranged from 2.20 to 3.0, indicating that interveners rated parents as having above average parent involvement qualities. At Reassessment #2, only the parents in the early intervention group were rated by the intervener. The mean scores of 2.2 and above indicate favorable ratings. At Reassessments #2 and #3, parents of children in the delayed intervention group were consistently rated more favorably by the intervener than were the early intervention group with five of the six comparisons being statistically significant. These findings are puzzling. Possibly the parents in the delayed group were more involved in the intervention because they had "missed" the earlier opportunity. However, with the delayed intervention group reporting fewer intervention sessions with the project intervener at each reassessment (refer back to Table 5.6), this explanation seems doubtful. Another explanation might be that the interveners rated the parents they knew better more realistically than they did the parents they had less contact with. The intervener ratings were discontinued when the intervention service component of the project ended in September 1990.

Although the parents' involvement were rated somewhat differently by the interveners, over all the other contextual variables (including demographic variables, family functioning scores, and child health), the two groups remained comparable over the course of the study. Thus, the influence of these contextual variables on the outcome measures of child development and family functioning would appear to be similar for both the early and the delayed intervention groups.

Table 5.8
Comparability of Contextual Factors for the Delayed and Early Intervention Groups for the Salt Lake City Medically Fragile Age-at-Start Study

	Delayed Intervention			Early Intervention				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES[·]
18-MONTH REASSESSMENT #1								
• Key Family Demographics								
Child living with both parents (%)	85.7		28	93.3		30	.35	.22
Mother's hrs. of work per week	11.8	(17.0)	27	13.9	(16.9)	29	.65	.12
Total income	$27,827	(20,629)	26	$33,111	($21,011)	27	.36	.26
Receiving public assistance (%)	29.6		27	30.0		30	.98	-.01
• Family Functioning								
Family Stressors (FILE)[◆]	12.0	(6.3)	28	10.8	(6.8)	28	.48	.19
Family Resources (FRS)[▲]	121.9	(18.2)	28	130.1	(21.1)	29	.12	.45
Family Adaptability and Cohesion (FACES)[+]								
Adaptability	24.0	(5.3)	28	23.3	(6.6)	28	.64	-.14
Cohesion	41.4	(5.2)	28	43.8	(7.0)	28	.39	.25
• Child Health[@]	1.7	(.5)	18	2.0	(.6)	22	.17	.65
• Infant Temperament Questionnaire[•]								
Activity	4.3	(.7)	27	4.3	(.6)	30	.89	-.03
Rhythmicity	2.8	(.6)	27	2.7	(.7)	30	.52	.18
Approach	2.7	(.6)	27	2.7	(.9)	30	.83	-.08
Adaptability	2.4	(.5)	27	2.4	(.5)	30	.74	.09
Intensity	3.6	(.8)	27	3.5	(.7)	30	.56	.14
Mood	3.1	(.6)	27	2.9	(.7)	30	.30	.31
• Intervener Rating of Parents[*]								
Attendance				2.6	(.6)	25		
Support				2.3	(.6)	25		
Knowledge				2.2	(.7)	25		
30-MONTH REASSESSMENT #2								
• Key Family Demographics								
Child living with both parents (%)	88.9		27	89.7		29	.93	.03
Mother's hrs. of work per week	12.2	(15.6)	26	13.7	(17.4)	24	.75	.10
Total income	$29,630	($20,157)	27	$30,982	($23,349)	28	.82	.07
Receiving public assistance (%)	26.9		26	34.6		26	.56	-.15
• Family Functioning								
Family Stressors (FILE)[◆]	11.1	(7.9)	27	9.7	(6.3)	29	.46	.18
Family Resources (FRS)[▲]	120.3	(20.8)	27	125.9	(18.7)	29	.29	.27
Family Adapt./Cohesion (FACES)[+]								
Adaptability	24.8	(7.3)	27	24.0	(5.1)	29	.66	-.11
Cohesion	41.7	(5.1)	27	42.6	(4.8)	29	.51	.18
• Child Health[@]	1.8	(.6)	26	2.1	(.6)	26	.09	.50
• Toddler Temperament Scale[•]								
Activity	3.8	(.8)	25	3.9	(.7)	27	.63	-.13
Rhythmicity	2.9	(.9)	25	2.7	(.6)	27	.37	.21
Approach	3.2	(1.1)	25	3.1	(1.1)	27	.78	.08
Adaptability	2.9	(.9)	25	2.9	(.8)	27	.80	.07
Intensity	3.9	(.8)	25	3.9	(.9)	27	.97	.01
Mood	3.1	(.8)	25	2.8	(.6)	27	.27	.28
• Intervener Rating of Parents[*]								
Attendance	2.8	(.5)	24	2.4	(.8)	26	.09	-.80
Support	2.7	(.6)	23	2.3	(.7)	26	.03	-.67
Knowledge	2.7	(.5)	24	2.2	(.8)	26	.01	-1.00

(continued)

[·] $$ES = \frac{\text{Early Intervention } \bar{x} - \text{Delayed Intervention } \bar{x}}{\text{Delayed Intervention SD}}$$ Positive ES indicates that the early intervention group is doing better than the delayed intervention group.

[◆] Analyses for the FILE are based on raw scores. Lower scores are considered better.

[▲] Analyses for the FRS are based on raw scores indicating number of resources indicated by the family as being available. Higher scores and positive ESs are considered better.

[+] Linear scoring (Olson, 1991) is used; higher scores are considered better.

[•] On the temperament scales, aspects of temperament are reported by parent on a scale of 1 to 6. Lower scores represent temperament aspects that are more easily handled. Hence, lower scores are better.

[*] Scores based on a 3-point rating (low to high) by the intervener most involved with the family infants and families in the delayed intervention group received no services via the project prior to 18 months of age; therefore, intervenor ratings of parent involvement were not collected.

[@] Child health reflects mother's perception of child's general health during the previous year, on a 3-point scale, ranging from worse than to better than other children.

Table 5.8 (continued)

Comparability of Contextual Factors for the Delayed and Early Intervention Groups for the Salt Lake City Medically Fragile Age-at-Start Study

	Delayed Intervention			Early Intervention				
	x̄	(SD)	n	x̄	(SD)	n	p Value	ES^
42 MONTH REASSESSMENT #3								
• Key Family Demographics								
Child living with both parents (%)	81.5		27	88.9		27	.45	.19
Mother's hrs. of work per week	12.7	(19.2)	25	16.5	(18.2)	27	.47	.20
Total income	$32.870	($24,285)	27	$34,800	($25,500)	27	.78	.08
Receiving public assistance (%)	37.0		27	32.1		28	.71	.10
• Family Functioning								
Family Stressors (FILE)♦	9.9	(5.8)	27	9.4	(6.0)	28	.72	.09
Family Resources (FRS)'	122.9	(19.8)	27	123.9	(19.2)	28	.86	.05
Family Adaptability and Cohesion (FACES)'								
Adaptability	23.8	(4.3)	27	24.3	(4.1)	28	.70	.12
Cohesion	41.2	(4.9)	27	41.3	(4.3)	28	.98	.02
• Child Health•	1.9	(.4)	27	2.1	(.5)	27	.09	.50
• Intervener Rating of Parents*								
Attendance	2.9	(.3)	20	2.5	(.7)	24	.02	-1.29
Support	2.7	(.6)	20	2.7	(.6)	24	.93	.00
Knowledge	3.0	(.2)	20	2.7	(.5)	24	.02	-1.36
54 MONTH REASSESSMENT #4								
• Key Family Demographics								
Child living with both parents (%)	82.1		28	87.0		23	.65	.10
Mother's hrs. of work per week	16.9	(18.5)	25	14.9	(17.4)	23	.69	-.11
Total income	$33,115	($21,502)	26	$36,625	($24,023)	24	.59	.16
Receiving public assistance (%)	26.9		26	22.7		22	.75	.08
• Family Functioning								
Family Stressors (FILE)♣	8.6	(5.0)	27	11.1	(8.0)	26	.18	.50
Family Resources (FRS)'	124.7	(19.5)	27	124.7	(17.1)	23	.99	.00
Family Adaptability and Cohesion (FACES)'								
Adaptability	22.0	(5.1)	27	25.9	(7.0)	25	.03	.76
Cohesion	41.0	(4.9)	27	42.6	(3.1)	25	.19	.32
• Child Health•	2.0	(.6)	26	2.1	(.5)	25	.44	.17
• Behavioral Style Questionnaire•								
Activity	3.8	(.6)	25	3.6	(.7)	26	.30	.33
Rhythmicity	3.2	(.7)	25	3.0	(.5)	26	.27	.28
Approach	3.0	(.9)	25	3.0	(.8)	26	.71	.00
Adaptability	3.1	(.9)	25	2.8	(.8)	26	.18	.33
Intensity	4.3	(.7)	25	4.4	(.5)	26	.67	-.14
Mood	3.5	(.8)	25	3.3	(.7)	26	.36	.25
66 MONTH REASSESSMENT #5								
• Key Family Demographics								
Child living with both parents (%)	84.0		25	91.7		24	.42	.19
Mother's hrs. of work per week	15.8	(17.4)	19	12.8	(16.8)	24	.57	-.17
Total income	$35,115	($22,937)	26	$39,313	($26,341)	24	.55	.18
Receiving public assistance (%)	28.6		21	23.8		21	.73	.09
• Family Functioning								
Family Stressors (FILE)♣	7.5	(4.7)	25	10.3	(8.8)	27	.17	.60
Family Resources (FRS)'	124.5	(21.6)	25	126.6	(18.8)	27	.71	.10
Family Adaptability and Cohesion (FACES)'								
Adaptability	22.7	(5.2)	25	24.0	(4.7)	27	.36	.25
Cohesion	42.8	(5.1)	25	40.9	(6.1)	27	.22	-.37
• Child Health•	2.1	(.6)	24	2.2	(.5)	27	.50	.17

(refer to legend on previous page)

(continued)

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Table 5.8 (continued)

Comparability of Contextual Factors for the Delayed and Early Intervention Groups for the Salt Lake City Medically Fragile Age-at-Start Study

	Delayed Intervention			Early Intervention			p Value	ES[*]
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n		
78 MONTH REASSESSMENT #6								
• Key Family Demographics								
Child living with both parents (%)	80.0		25	86.4		22	.57	.14
Total income	$36,583	($17,475)	24	$37,952	($23,356)	21	.82	.08
• Family Functioning								
Family Resources (FRS)[a]	125.5	(18.3)	24	124.7	(20.4)	22	.89	-.04
• Holmes-Rahe								
Stress Score	117.2	(69.7)	23	177.6	(145.8)	21	.10	.87
Negative Events Score	21.4	(44.6)	23	23.4	(38.3)	21	.88	.05
• Child Health	2.2	(.6)	18	2.3	(.6)	18	.42	.16
90 MONTH REASSESSMENT #7								
• Key Family Demographics								
Child living with both parents (%)	81.3		16	100		18		.51
Total income	$32,594	($15,614)	16	$34,316	($16,062)	19	.75	.11
• Family Functioning								
Family Resources (FRS)[a]	123.0	(21.5)	16	126.8	(18.4)	21	.57	.18
• Holmes-Rahe								
Stress Score	145.0	(71.8)	16	159.0	(120.5)	20	.67	.19
Negative Events Score	36.5	(40.1)	16	53.2	(77.4)	20	.41	.42
• Child Health	2.2	(.6)	17	2.3	(.6)	20	.73	.18

(refer to legend on previous page)

Cost of Alternative Interventions

The cost per child for the early intervention group (included 23 children at the time the cost comparison was performed) represents an accumulated cost of intervention from July 1986 to July 1988, the total program cost for two years and two phases of intervention as outlined under the intervention program description. For the delayed intervention group, the cost for services was from the date these children started intervention at 18 months of age until July, end of FY 1987-88. In Table 5.9, all cost estimates were adjusted for inflation to 1990 dollars.

To arrive at the cost per child, total program costs were determined for each group and divided by the number of children in the group. As illustrated in Table 5.9, program costs included direct service and program and university administration, occupancy, equipment, transportation, and materials and supplies used for the respective groups.

Table 5.9

Cost Per Child for Two Years of Intervention (1986 - 1988) for the Salt Lake City Medically Fragile Age-at-Start Study (1990 dollars)

Resources	Early Intervention (n = 23)	Delayed Intervention (n = 29)
Agency Resources		
Direct service personnel	$ 2,101	$ 693
Administration		
program	395	127
university	126	40
Occupancy	250	78
Equipment	149	45
Transportation	49	19
Materials/supplies	60	30
SUBTOTAL	**$ 3,130**	**$1,032**
Contributed Resources		
Parent Time	2147	716
Parent Transportation	157	97
SUBTOTAL	**$ 2,304**	**$ 813**
Total	**$ 5,434**	**$1,845**

**Totals may not add up due to rounding errors.*

Personnel costs included wages and benefits for the physical therapist, the developmental specialist, diagnosticians, a graduate assistant, and a secretary. Each of these were pro-rated according to actual time spent on intervention-related activities. Research costs in this, and all other resource categories, naturally, were excluded. Program administration included salaries and benefits for the percentage of FTE administrative personnel worked on the project. The university administrative cost applied to the small portion of the project that was operated out of Utah State University. For this, the university indirect rate for general, departmental, and sponsored projects administration was used (31.78%). Occupancy charges included rent paid for office space, utilities, maintenance, and insurance. Equipment costs included the cost of office furniture, computers, intervention toys and treatment equipment, and a supply of equipment available for loans to parents (seating devices, walkers, etc.). These costs were based on market replacement values for each item and annualized at a rate which accounted for interest and depreciation to determine the annual equipment cost. Agency transportation costs for home visits were calculated at $.21 per mile based on actual mileage.

Because the program relied heavily on parent participation for both intervention and for transportation to the center, the opportunity cost of parent time was also determined. These costs were presented as "contributed resources" on Table 5.9. Parent time included time spent in (1) center and home visit sessions with either the physical therapist or the developmental specialist at one hour each; (2) intervention activities recommended by the program (20 minutes, 5 days per week) for each parent and child at home; and (3) transportation time and expenses. Parents spent an average of 142 hours in Year One and 71 hours in Year Two in session with professionals and conducting intervention activities at home. Parent transportation costs in Year Two were gathered via telephone interview during which parents reported the number of trips taken to the center, the round-trip distance, and travel time. As reported in the economic section of the report, parent time was assigned the value of $9 per hour based on the average hourly earnings plus benefits for all working women in the U.S.

For children entering the program at 3 months CCA and receiving two years of individualized intervention from both professionals and their parents, the undiscounted cost of the program was $5,434 per child; for children entering the program later at 18 months, the cost was $1,845, including the value of parent time. The cost per child for two years of intervention is more than twice the cost for one year. This can be attributed to the emphasis on physical therapy in Year 1, which cost more than services from the developmental specialist which began at 18 months.

Data Collection

Data were collected to determine the effects of intervention upon the child and the family. The assessment instruments were chosen to provide some consistency of data collection across sites, but also to provide information about children with intraventricular hemorrhage at birth and the unique experiences of their families. Table 5.10 presents a schedule of assessment and reassessment measures as well as the ages at which they are administered. Table 5.11 provides a description of the measures.

Table 5.10

Schedule of Administration of Measures for Salt Lake City Medically Fragile Age-at-Start Study

	Assess. 3 month	6 month	12 month	Reassess. 1 18 month	Reassess. 2 30 month	Reassess. 3 42 month	Reassess. 4 54 month	Reassess. 5 66 month	Reassess. 6 78 month	Reasses. 7 90 month
CHILD MEASURES										
Battelle Developmental Inventory	X			X	X	X	X	X		
Child Health				X	X	X	X	X	X	X
Binet Screening Test					X	X	X	X		
Preschool Language Scale						X	X			
Draw-A-Person							X	X		
Visual Motor Integration							X	X		
Infant Temperament Questionnaire		X								
Toddler Temperament Questionnaire					X					
Carey Behavioral Style Checklist							X			
Child Behavior Checklist							X	X	X	X
Parent-Child Interaction Video			X		X	X	X	X		
Motor Video			X							
Bruininks-Oseretsky								X		
Woodcock-Johnson, Revised									X	X
Scale of Independent Behaviors									X	X
Pictorial Scale of Perceived Competence									X	X
Social Skills Rating Scale									X	X
FAMILY MEASURES										
FSS	X			X	X	X	X	X	X	X
FRS	X			X	X	X	X	X	X	X
FACES	X			X	X	X	X	X	X	
Demographics	X			X	X	X	X	X		X
FILE	X			X	X	X	X	X		
PSI--Long Form	X			X	X	X	X	X		
PSI--Short Form									X	X
Family APGAR									X	X
Parent Self-Awareness									X	
Holmes-Rahe									X	X
Additional Services				X	X	X	X	X	X	
	X									
TEACHER MEASURES*										
Educational Services										
Rating of Parent Participation										

* Not assessed by child's age; assessed in school years 1992-93 and 1993-94.

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Table 5.11

Description of Tests Administered for Salt Lake City Medically Fragile Age-at-Start Study

MEASURES	DESCRIPTION
CHILD MEASURES	
Battelle Developmental Inventory (BDI) (Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984)	A norm-referenced test of developmental functioning completed through child administration and parent interview. Assesses personal/social, adaptive, motor, communication, and cognitive skills, and provides a total score.
Child Health (E.I.R.I.)	Assesses the parents' evaluation of the child's health during the past year, including general health, illnesses, hospitalization, etc.
Stanford-Binet Screening Test (Thorndike, Hagon, & Sattler, 1986)	Measures general intellectual ability for individuals from ages 2 to 18. One subtest is used from each of the following subtests: vocabulary, pattern analysis, quantitative, and bead memory.
Preschool Language Scale (PLS) (Zimmerman, Steiner, & Evatt, 1969)	Evaluates language strengths and deficits in the areas of auditory comprehension and verbal ability. It also assesses articulation and is designed for children ages 18-months to 7 years.
Draw A Person (D.A.P.)	The child is given a blank piece of 8" x 11" paper and asked to draw him (her) self. A raw score and age equivalent rating is determined by the number of body parts that are drawn and the proportion and detail of those parts.
Developmental Test of Visual-Motor Integration (V.M.I.) (Beery, 1989)	This measure includes a 24-item developmental sequence of geometric forms that is intended to identify early learning and behavioral problems. It is a paper and pencil test that can be administered individually or in groups.
Infant Temperament Scale (I.T.S.) (Carey & McDevitt, 1977)	This scale is a 95-item questionnaire that assesses the primary caregivers' estimate of the 4- to 8-month infant's temperament. Six aspects of temperament are each rated on a scale of 1 to 6, with high scores representing behavior more difficult to handle. Scoring categorizes infant behavior into easy, intermediate, slow-to-warm and difficult clusters.
Toddler Temperament Scale (TTS) (Fullard, McDevitt, & Carey, 1982)	This scale is a 99-item questionnaire completed by the primary caregiver. It is designed to assess the temperament or behavioral style in 1- to 3-year-old children. Scoring categorizes the toddler into easy, intermediate, slow-to-warm, and difficult clusters.
Behavioral Style Questionnaire (BSQ) (McDevitt & Carey, 1975)	This scale is a 100-item questionnaire completed by the primary caregiver. It assesses the temperament or behavioral style in 3- to 7-year-old children. Scoring categorizes the child into easy, intermediate, slow-to-warm, and difficult clusters.
The Child Behavior Checklist for Ages 4 to 5 (CBCL) (Achenbach, 1991)	This test is designed to obtain standardized data on children's social competencies and internalizing and externalizing behavioral problems as reported by their parents.
Parent/Child Interaction (E.I.R.I.)	A 15- to 20-minute videotape of parent-child interaction following a set protocol devised by EIRI.
Videotaped Assessment of Motor Functioning (Peterson & Miller, 1985)	A videotaped procedure assessing quality of spontaneous motor development in 12-month-old infants.
The Bruininks-Oseretsky Test of Motor Proficiency (Bruininks, 1978)	This is an individually administered test of gross and fine motor functioning of children from 4-1/2 to 14-1/2 years of age. The test contains 46 items divided among eight subtests. Scores are obtained for an overall composite, gross motor and fine motor domains, and for each subtest.

(continued)

Table 5.11 (continued)

MEASURES	DESCRIPTION
Woodcock-Johnson Tests of Achievement--Revised (WJ-R) (Woodcock & Johnson, 1989)	A norm-referenced test of achievement. The test consists of six aspects of scholastic achievement: Letter-Word Identification, Applied Problems, Dictation, Science, Social Studies, and Humanities. Child is the respondent.
The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983)	Assesses a child's perceived competence and social acceptance in four specific domains: Cognitive Competence, Physical Competence, Maternal Acceptance, and Peer Acceptance. Child is the respondent.
Scales of Independent Behavior (SIB) (Bruininks, Woodcock, Weatherman, & Hill, 1985)	The SIB is a norm-referenced test which assesses the functional independence and adaptive behavior of a child. The test is organized into four subdomains: Motor Skills, Social and Communication Skills, Personal Living Skills, and Community Living Skills. Parent is interviewed for information.
Social Skills Rating System --Parent Form (PSSRS) --Teacher Form (TSSRS) (Gresham & Elliot, 1990)	The PSSRS/TSSRS measures the parent/teacher estimate of the child's social skills (control, assertion, and self-control) and problem behaviors (externalizing, internalizing, and hyperactivity). The PSSRS also measures responsibility as part of social skills and the TSSRS provides an estimate of academic competence.
FAMILY MEASURES	
Family Support Scale (FSS) (Dunst, Jenkins, & Trivette, 1984)	Assesses the availability of sources of support as well as the degree to which different sources of support provided perceived as helpful to families rearing young children.
Family Resource Scale (FRS) (Dunst & Leet, 1985)	Assesses the extent to which different types of resources are perceived as adequate in households with young children. Factors include: General Resources, Time Availability, Physical Resources, and External Support.
Family Adaptability and Cohesion Evaluation Scale - III (FACES) Olson, Portner, & Lavee, 1985)	Provides a general picture of family functioning by assessing the family's level of adaptability and cohesion. Family cohesion assesses degree of separation or connection of family members to the family. Adaptability assesses the extent to which the family system is flexible and able to change in various situations.
Family Inventory of Life Events and Changes (FILE) (McCubbin, Patterson, & Wilson, 1983)	Assesses life events and changes experienced by a family unit during the past 12 months and prior to the past 12 months. The specific areas of potential strain covered by the scale include: Intra-Family, Marital, Pregnancy and Childbearing, Finance and Business, Work-Family Transitions, Illness and Family "Care", Losses, Transitions "In and Out", and Legal.
Parenting Stress Index (PSI) (Abidin, 1983)	Assesses parent perceptions of stress on the parent-child system. The two main domains are child-related stress and stress in other aspects of parent's life (e.g., depression, isolation, health).
Parenting Stress Index Short Form (Abidin, 1990)	36 item version of the PSI that provides 3 scores: parent distress, parent-child dysfunctional interaction, and difficult child.
Parent Self-Awareness Scale (PSAS) (Snyder, Weeldreyer, Dunst, & Cooper, 1985)	The PSAS is a 20-item questionnaire that measures the parent's perceived level of personal capabilities, decision-making capabilities, and informational capabilities.
Social Readjustment Rating Scale (SRRS) (Holmes & Rahe, 1967)	The SRRS measures parental stress by assigning numerical values to various positive and negative life events occurring within the last year. A separate score of the occurrence of major negative events is also provided.
Family APGAR (Smilkstein, 1978)	The family APGAR assesses five functional components of family life by presenting five statements to which the parent responds using a Likert-type format. Family functions include: Adaptability, Partnership, Growth, Application, and Resolve.
Additional Services (E.I.R.I.)	Provides data on services the child and family have received during the past year outside the study (e.g., schooling, early intervention, speech therapy, physical and occupational therapy, and tutoring).

(continued)

Table 5.11 (continued)

MEASURES	DESCRIPTION
TEACHER MEASURES	
Educational Services (EIRI, 1993)	Provides description of child's educational placement including disability, eligibility status, type of classroom, related services received, etc.
Teacher Rating of Parent Participation--Revised (EIRI, 1991)	Teacher rates parent's participation in and knowledge concerning child's educational program on 3-point Likert scale, ranging from less than to more than other parents

Recruitment, training, and monitoring of diagnosticians. Rigorous certification procedures and requirements were implemented to ensure the qualifications and reliability of the diagnosticians administering assessments for this study. Diagnosticians were required to independently become familiar with the BDI through study of the test manuals and viewing of a videotaped test administration. The diagnosticians then completed a 1½ day BDI administration training session conducted by a certified assessment trainer. During the training session, BDI testing procedures were explained, demonstrated, and practiced. Following the training session, diagnosticians completed three practice BDI administrations. The final practice administration was videotaped and then reviewed by the assessment coordinator. Diagnosticians either had advanced degrees in psychology or special education, or were Ph.D. candidates in psychology. Diagnosticians were "blind" to the child's group assignment.

To maintain records on the continued quality of the test results, shadow scoring of 10% of test administrations for each diagnostician was conducted by another trained diagnostician. Interrater reliability indicated that the diagnosticians are administering the tests correctly with a reliability level above .90.

Initial assessment. The initial assessment was completed when the infants were at 3 months CCA (prematurity corrected to 40 weeks plus 3 months). The measures used are listed in Table 5.10. Parent measures indicated as being given at the initial assessment were not completed by all parents; some measures were introduced after the first subjects had already entered the study. All test and questionnaire protocols were sent to the EIRI site coordinator for scoring and placement in the EIRI file. Parents were paid $20 for their time in completing the evaluation session. This battery of tests provided information regarding both the infant's developmental level and early family reaction to the new-born.

Interim testing. When infants were 6 months CCA their parents were mailed the Carey Infant Temperament Scale to complete. This questionnaire was returned directly to the site coordinator via postpaid mail. Parents were paid $10 for completing the questionnaire.

Videotapes of parent-infant interaction and motor development were completed by a trained child development specialist or a licensed physical therapist when the infants were 12 months CCA. These videotaped sequences were rated by trained individuals who were "blind" to the study design and group membership of subjects. Parents were paid a $10 incentive for videotaping. The parent-child interaction videotape involved the parent and child in play activities; a protocol used by all the EIRI sites was followed. In the first section, the mother and child played together for 15 minutes "as they would at home." Then for one minute the parent encouraged the child to put the toys away. For the next two minutes, the parent read to the child. Then the parent left the room for 45 seconds. Taping continued for two minutes after the parent returned to the room.

The videotape of motor functioning followed a specific script. The motor script encouraged the child to perform the following behaviors (based upon the child's level of motor development): reaching and grasping from a supine position, rolling over and reaching and grasping from a prone position, creeping and crawling, sitting and reaching, pulling self up to stand, walking, and squatting to pick up a toy.

Reassessments. Infants were reassessed at 18 months corrected age and annually thereafter according to the schedule in Table 5.10. The measures are explained in

Table 5.11. Appointments were made with the parents for the annual assessment. Most children were tested in their homes, but a few were completed at mutually convenient places. The measures to be completed by the parent were mailed prior to the testing and were collected by the diagnostician at the time of the child's assessment. Parents were paid for each assessment (Reassessment #1, \$20; Reassessment #2, \$25; Reassessments #3 and #4, \$35; Reassessment #5, \$40; and Reassessments #6, 7, and 8, \$50.)

In addition to the diagnostician who performed the child development assessments, at Reassessment #5, an occupational therapist performed the Bruininks-Oseretsky Test of Motor Proficiency. The Bruininks-Oseretsky Test of Motor Proficiency (B & O), an extensive measure of gross and fine motor functioning was scheduled to be administered to all the subjects as part of the 66-month assessment. The assessment, given by a licensed physical or occupational therapist, required approximately two hours to complete and cost approximately \$80 per subject. Sixteen subjects were assessed with the B & O. T-test comparisons between the groups (n = 8 + 8) showed no statistically significant group differences. Because the correlations of the B & O fine motor, gross motor, and total score with the BDI fine motor, gross motor, and total motor scores were very high (range of r = .73 to .83), it appeared that this costly assessment was not adding any new information. Therefore, its use was discontinued.

By June 1, 1994, the first five reassessments were completed; the 78-, 90-, and 102-month reassessments were partially completed. Table 5.12 reports the assessments to date.

In the Spring of 1993, 55 of the families (all of the families who were participating in the study at that time) were surveyed via telephone. They were interviewed concerning their child's education and present health behavioral conditions. At this time, the mean child age was 7 years, ranging from 4 years 9 months to 8 years 5 months.

Table 5.12

Testing Schedule for Salt Lake City Medically Fragile Age-at-Start Study

Time of Assessment	Number Assessed to Date
3 Months	58
18 Months	58
30 Months	57
42 Months	57
54 Months	54
66 Months	55
78 Months	49
90 Months	40
102 Month	20

Statistical procedures. Analysis of covariance procedures were used to measure differences between groups on measures of child and family functioning. Treatment group served as the independent variable and the dependent variables were scores obtained on the assessment instruments described previously. Analysis of covariance (using MANOVA commands with the SPSSPC software) was the primary method used to compare the two groups. Analyses other than analysis of covariance procedures are described as such in the text and/or table. Analysis of covariance procedures were used for two reasons: (a) to increase the statistical power of the study by reducing error variance; and (b) to adjust for any pretreatment differences which were present between the groups. In either application, the degree to which analysis of covariance is useful depends on the correlation between the covariate(s) selected and the outcome variable for which analyses are being done. However, since one degree of freedom is lost for each covariate used, the number of covariates was limited in any given analysis. The final selection of covariates depended on a judgment of which variable or set of variables could be used to maximize the correlation or multiple correlation with the outcome variable in question and still include those demographic or assessment variables for which there were the largest pretreatment differences. Measures of neonatal medical risk and family demographic indices were considered as covariates, following the rationale of other studies of low birthweight infants (e.g., Brooks-Gunn, Liaw, & Klebanor, 1992; IHDP, 1990). The number of days spent in the intensive care unit and the mother's age were the most frequently used covariates in the analysis of child developmental outcomes. The specific covariates used are indicated in the table. Variables that reflect environmental influences (e.g., economic risk) were also used when the children were older because research (e.g., Smith, Ulvand, & Lindemann, 1994) has demonstrated that these variables influence child development.

Although sample sizes for this study are as large or larger than previous early intervention studies with these types of children, the statistical power of the analysis is still a concern. By setting the alpha level for all tests of statistical significance at $p \leq .10$ and by using analysis of covariance procedures, the statistical power of the analyses was substantially increased. According to Hopkins (1973) and Cohen (1977) in those cases where a covariate or set of covariates could be found which correlated with the dependent variable in question (which was almost always the case in these analyses), and with alpha set at $p \leq .10$, the statistical power was approximately 75% for finding moderate-sized differences (defined by Cohen as differences of a half-a-standard deviation.) Setting alpha at .10 balances the probability of Type I and Type II error and is consistent with most of the recent thinking about statistical significance testing (e.g., Cohen, 1990).

Results and Discussion

The purpose of the Salt Lake City Medically Fragile At-at-Start study was to compare the effectiveness of intervention begun early (at 3 months CCA) to intervention begun later (at 18 months CCA) for children with histories of perinatal intraventricular hemorrhage. The children were initially assessed when they were 3 months CCA, and reassessed at 18 months CCA, and yearly thereafter. The reassessment analyses reported here included all children who participated in the 18-, 30-, 42-, 54-, 66-, 78-, and 90-month reassessments.

Comparability of Groups on Initial Assessment Measures

As was noted in the section on initial family demographic comparisons, the families in the delayed and early intervention groups were very comparable (see Table 5.1). Few statistically significant differences were found between the groups. The differences included mother's age, father's education level, and percent of fathers employed as technical/managerial or above. In the early intervention group, the mothers were older and fathers had more education and their employment was more often in the technical/managerial categories. These differences may signify a slight socio-economic advantage for the early intervention group.

The maternal pregnancy characteristics were very similar for the two groups (see Table 5.2). The child hospital characteristics were also comparable, with a possible advantage being in favor of the delayed intervention group.

At the adjusted age of 3 months, child functioning was measured with the Battelle Developmental Inventory (BDI). The BDI is a norm-referenced, standardized assessment of development in children from birth to 8 years of age and assesses five developmental domains: personal social, adaptive, motor (gross and fine), communication (receptive and expressive), and cognitive; a total developmental score is also provided. When the scores of the two groups were compared, the groups were found to be similar in the personal/social, adaptive, and cognitive domains. However, statistically significant differences were found on the motor and communication domains (motor $p = .01$, ES = .61, communication $p = .01$, ES = .64) with the children in the early intervention scoring higher than the children in the delayed intervention group (see Table 5.13).

Two issues from these findings are relevant to interpreting the outcome data. First, does the statistically significant differences in scores reflect real functional differences? In administering the Battelle to 3-month-old infants, 6 or less items are used for each domain. Therefore, the difference in mean scores

Table 5.13

Comparability of Initial Child and Family Measures for Salt Lake City Medically Fragile Age-at-Start Study

Variable	Delayed Intervention $\bar{x}$	(SD)	%ile	n	Early Intervention $\bar{x}$	(SD)	%ile	n	p Value	ES
• Age at assessment (months)	3.4	(.7)		28	3.3	(.5)		30	.46	-.14
• **Battelle Developmental' Inventory (BDI)**										
Personal/Social	17.9	(4.8)		28	19.1	(5.0)		30	.35	.25
Adaptive Behavior	13.1	(3.5)		28	14.1	(2.9)		30	.25	.29
Motor	12.3	(3.3)		28	14.3	(2.2)		30	.01	.61
Communication	9.3	(2.2)		28	10.7	(1.7)		30	.01	.64
Cognitive	6.5	(2.8)		28	7.3	(2.4)		30	.21	.29
TOTAL	59.0	(14.4)		28	65.6	(9.9)		30	.05	.46
• **Parenting Stress' Index (PSI)**										
Child Related (range 47 to 235)	106.3	(21.4)	67	22	100.7	(19.7)	57	24	.36	.26
Other Related (range 54 to 270)	132.7	(29.8)	71	22	124.5	(19.2)	58	24	.27	.28
TOTAL (range 101 to 505)	239.0	(40.8)	70	22	225.0	(34.9)	56	24	.22	.34

$$ES = \frac{\text{Early Intervention } \bar{x} - \text{Delayed Intervention } \bar{x}}{\text{Delayed Intervention SD}}$$

Positive ES indicates that the early intervention group is doing better than the delayed group.

' Statistical analyses for BDI scores were conducted using raw scores for each of the scales.

' Statistical analyses and Effect Size (ES) estimates for PSI were based on raw scores where low raw scores and positive ESs are most desirable. For each of interpretation, the table also includes an approximate percentile based on the covariance adjusted score and the norming sample reported in the technical manuals. A low percentile score indicates low stress.

probably reflects the difference in completing one item. Second, how well do BDI developmental scores at 3 months of age predict later development? With a sample of 30 infants ranging in age of 5 months to 30 months, the correlations of the BDI with the Bayley Scales of Infant Development (Bayley, 1969) ranged from .27 to .95 (Boyd, Welge, Sexton, & Miller, 1989) indicating concurrent validity for the BDI scales. However, as Bayley (1970) herself states, there is often no correlation between the IQ scores measuring sensorimotor abilities attained by normal babies and their subsequent IQ scores. The same statement is probably true for infants born with physical disabilities or at risk for such disabilities. In comparing correlations of initial assessment and reassessment BDI scores in the present EIRI studies, much higher correlations between the initial assessment and Reassessment #1 were found for those who were of preschool age at the time of the initial assessment (correlations ranging from .32 to .91) than for those in this study who were 3 montns adjusted age at assessment. These correlations ranged from .04 to .49. Because of the concerns of possible inaccurate measurement of development of very young infants, the initial BDI scores were not used as covariates in the analyses of child development outcomes.

The Parenting Stress Index (Abidin, 1986) was completed by a parent in 46 of the families. The Parenting Stress Index provides two subscores, child-related stress and parent-related stress, and a total parenting stress score. With this reduced sample, significant differences were not found between the scores on parenting stress, but the percentiles and the effect sizes indicate that the parents in the early intervention group reported slightly less stress than did the parents in the delayed intervention group. Because only 80% of the families completed the PSI at the initial assessment, the PSI scores were not used as covariates in any of the analyses of child or parent outcomes.

In summary, there are slight advantages in favor of the delayed intervention group on medical characteristics, and slight advantages for the early intervention group on family demographic characteristics, initial assessment of child development, (BDI), and parenting stress. When these differences are considered together, particularly in light of the number of tests of statistical significance that were performed, it appears that the groups were very comparable at the initial assessment and that random fluctuation may at least partially account for the differences that existed.

Effects of Early Versus Delayed Intervention on Measures of Child Functioning

Table 5.14 reports results of ANCOVA comparisons for the child outcome measures at 18, 30, 42, 54, 66, 78, and 90 months of age. The 78- and 90-month cohorts are not yet complete. Child development was measured by the Battelle Developmental

Inventory (BDI) across Reassessments #1 to #5 and by the Woodcock-Johnson Revised Test of Achievement (WJ-R) and the Scales of Independent Behavior (SIB) at Reassessment #6 and #7. Almost all the adjusted raw score comparisons favor the early intervention group. There were no significant differences at Reassessments #1 and #2 between the two group's developmental scores. However, at Reassessment #3, #4, and #5, statistically significant differences for the total BDI raw scores and in several of the subdomains were found favoring the early intervention group.

At the 78-month reassessment, the Woodcock Johnson--Revised Achievement Test (WJ-R) and the Scales of Independent Behavior (SIB) were administered because the children were too old for the BDI measure of development. Two scores for the WJ-R (broad knowledge total and skills knowledge total) and scores for four domains of independent (developmental) skills (motor, social-communication, personal living, and community) and a total score for the SIB were analyzed. The mean scores for the early intervention group were higher than those for the delayed group across these measures, but only the differences for the WJ-R broad knowledge score, and the SIB motor and social/communication scores were statistically significant.

The Stanford Binet Screening Test was used to measure the children's intelligence on second through fifth reassessments. No statistically significant differences were found at any of the reassessments between the adjusted mean scores of the two groups. From 2 to 5 children at each reassessment were not assessed with this instrument. Some of the children were too developmentally delayed to complete this assessment, while others simply missed the assessment.

A measure of language development, the Preschool Language Scale (PLS), was completed by the children at the ages of 42 and 54 months (Reassessments #3 and #4). Auditory comprehension and verbal ability standard scores and a total language quotient are reported in Table 5.15. These scores provide an additional measure of

Table 5.14

Comparison of Reassessment Measures on Child Functioning for Children in Delayed and Early Groups in the Salt Lake Medically Fragile Age at Start Study

		Delayed Intervention				Early Intervention				ANCOVA	P	Effect
	Covariates[§]	$\bar{x}$	(SD)	Adj. $\bar{x}$[•]	n	$\bar{x}$	(SD)	Adj. $\bar{x}$[•]	n	F	Value	Size[*]
18-MONTH Reassessment (#1)												
Age in Months at Assessment #1		21.1	(1.3)		28	21.3	(.8)		30		.55	.15
Battelle Developmental Inventory (raw scores)												
Personal/Social	1,2	55.5	(12.2)	**54.3**	28	55.6	(15.2)	**56.8**	30	.51	.46	.20
Adaptive Behavior	1,2	40.6	(9.0)	**39.6**	28	41.1	(9.1)	**42.1**	30	1.50	.23	.28
Motor	1,2	59.8	(16.7)	**58.3**	28	61.4	(15.4)	**62.9**	30	1.37	.23	.27
Communication	1,2	28.7	(6.2)	**28.2**	28	29.1	(6.4)	**29.6**	30	.81	.34	.23
Cognitive	1,	22.1	(4.1)	**21.7**	28	21.9	(4.3)	**22.3**	30	.47	.52	.15
TOTAL	1,2	206.7	(40.6)	**202.1**	28	209.1	(44.5)	**213.8**	30	1.39	.23	.29
30-MONTH Reassessment (#2)												
Age in months at Assessment #2		32.9	(1.5)		28	33.0	(.9)		29	.28	.70	.07
Battelle Developmental Inventory (raw scores)												
Personal/Social	1,2	83.9	(20.5)	**82.2**	28	85.3	(23.9)	**86.9**	29	.47	.42	.23
Adaptive Behavior	1,2	54.5	(12.4)	**53.0**	28	56.6	(15.8)	**58.0**	29	2.08	.14	.40
Motor	1,2	78.5	(18.0)	**76.8**	28	79.9	(19.5)	**81.8**	29	1.22	.29	.28
Communication	1,2	40.4	(9.1)	**39.9**	28	41.0	(10.3)	**41.8**	29	.44	.46	.21
Cognitive	1,2	29.4	(7.4)	**28.9**	28	29.9	(7.7)	**30.3**	29	.43	.48	.19
TOTAL	1,2	286.6	(58.9)	**280.8**	28	292.8	(69.5)	**298.8**	29	1.12	.26	.31
Stanford Binet IQ[◆]	1,2,3	99.5	(9.7)	**98.7**	26	99.2	(10.5)	**100.0**	26	.23	.63	.13
42-MONTH Reassessment (#3)												
Age in Months at Assessment #3		42.6	(.5)		28	42.7	(1.0)		29	.25	.73	.20
Battelle Developmental Inventory (raw scores)												
Personal/Social	1,2	101.0	(22.9)	**100.1**	28	104.1	(26.7)	**105.0**	29	.58	.46	.21
Adaptive Behavior	1,2	67.5	(14.1)	**66.2**	28	71.0	(12.0)	**72.3**	29	4.03	.05	.43
Motor	1,2	90.5	(21.0)	**89.5**	28	93.3	(15.5)	**94.5**	29	1.13	.30	.24
Communication	1,2	53.8	(16.6)	**52.9**	28	58.4	(12.4)	**59.4**	29	3.05	.09	.39
Cognitive	1,2	39.3	(10.5)	**38.8**	28	43.7	(9.4)	**44.2**	29	4.28	.05	.51
TOTAL	1,2	352.2	(76.8)	**347.2**	28	373.6	(57.5)	**378.8**	29	3.63	.06	.41
Stanford Binet IQ[◆]	1,2,3	95.0	(12.7)	**94.4**	26	93.9	(11.4)	**94.5**	29	.00	.98	.01
Preschool Language Scale												
Auditory Comprehension	2,4	101.5	(17.9)	**101.0**	26	104.6	(19.5)	**105.1**	29	.75	.39	.23
Verbal Abilities	2,4	95.5	(21.7)	**95.5**	26	98.2	(21.4)	**98.2**	29	.24	.63	.12
Language Quotient	2,4	98.7	(18.6)	**98.4**	26	99.7	(20.0)	**100.0**	29	.10	.75	.09
54-MONTH Reassessment (#4)												
Age in Months at Reassessment #4[◆]		53.8	(.7)		28	54.0	(.8)		26	.73	.40	-.29
Battelle Developmental Inventory (BDI)												
Raw Scores for:												
Personal/Social	1,2,3	115.8	(30.3)	**113.6**	28	119.1	(21.2)	**121.3**	26	1.26	.27	.25
Adaptive Behavior	1,2,3	76.7	(18.2)	**75.1**	28	79.6	(12.3)	**81.2**	26	2.57	.12	.34
Motor	1,2,3	102.0	(27.1)	**100.2**	28	106.9	(20.7)	**108.8**	26	1.91	.17	.32
Communication	1,2,3	65.4	(18.3)	**63.3**	28	71.4	(14.5)	**73.5**	26	6.57	.01	.56
Cognitive	1,2,3	51.6	(16.0	**50.5**	28	57.7	(13.5)	**58.8**	26	4.90	.03	.52
TOTAL	1,2,3	411.7	(101.7)	**402.8**	28	434.7	(70.8)	**443.6**	26	3.58	.07	.40
Stanford Binet IQ[◆]	1,2,3	92.2	(15.3)	**90.7**	26	93.4	(13.9)	**95.0**	25	1.10	.30	.28
Preschool Language Scale												
Auditory Comprehension	2,3	102.8	(16.1)	**101.7**	25	101.7	(22.3)	**102.9**	26	.07	.80	-.08
Verbal Abilities	2,3	95.0	(18.6)	**94.1**	25	102.0	(22.0)	**102.8**	26	2.53	.12	.47
Language Quotient	2,3	99.0	(16.5)	**98.7**	25	98.2	(25.1)	**98.5**	26	.00	1.00	.01
Developmental Test of Visual Motor Integration (VMI)												
VMI Standard Scores	1,2,3	93.5	(12.9)	**93.1**	25	92.6	(12.0)	**93.0**	25	.00	.99	-.01
Child Behavior Checklist (CBCL)												
Internalizing Score	1,2,	47.2	(9.2)	**46.9**	26	48.2	(11.0)	**48.5**	26	.30	.60	-.17
Externalizing Score	1,2	50.9	(9.8)	**50.1**	26	50.7	(10.9)	**51.5**	26	.22	.64	-.14
Total	1,2	52.3	(9.9)	**51.9**	26	50.6	(12.7)	**51.0**	26	.07	.79	.09

(continued)

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[*] $ES = \frac{\text{Early Intervention Adj}\bar{x} - \text{Delayed Intervention Adj}\bar{x}}{\text{Delayed Intervention SD}}$ A more desirable outcome for the early group is indicated by a positive effect size.

[◆] Child age is coded in actual months of age and is not adjusted for prematurity.

[•] Covariance adjusted means.

[◆] Stanford Binet screening provided a composite IQ score.

[§] 1 = Days of care NICU, 2 = Age of mother, 3 = Annual income, 4 = Education of father

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Table 5.14 (continued)

Comparison of Reassessment Measures on Child Functioning for Children in Delayed and Early Groups in the Salt Lake Medically Fragile Age-at-Start Study

		Delayed Intervention				Early Intervention						
	Covariates*	$\bar{X}$	(SD)	Adj. $\bar{X}$*	n	$\bar{X}$	(SD)	Adj. $\bar{X}$*	n	ANCOVA F	P Value	ES*
66-MONTH Reassessment (#5)												
Age in Months at Reassessment #5*		66.1	(.8)		27	66.1	(.6)		28	.03	.86	**.00**
Battelle Developmental Inventory (BDI) (raw scores)												
Personal/Social	1,2,3	137.9	(25.8)	**136.1**	27	145.1	(7.4)	**146.9**	28	4.21	.05	**.42**
Adaptive Behavior	1,2,3	87.3	(18.8)	**86.0**	27	93.3	(12.1)	**94.6**	28	4.84	.03	**.46**
Motor	1,2,3	123.4	(30.0	**121.3**	27	129.6	(22.9)	**131.7**	28	2.71	.11	**.35**
Communication	1,2,3	81.5	(20.0)	80.1	27	85.6	(15.2)	**87.0**	28	2.68	.11	**.35**
Cognitive	1,2,3	75.6	(19.5)	**73.9**	27	77.7	(16.2)	**79.4**	28	1.91	.17	**.28**
TOTAL	1,2,3	503.4	(106.7)	**495.2**	27	531.5	(74.0)	**539.7**	28	4.58	.04	**.42**
Stanford Binet IQ*	1,2,3,	94.0	(11.3)	**92.9**	26	96.0	(12.8)	**97.1**	27	1.85	.18	**.37**
Developmental Test of Visual Motor Integration (VMI)												
VMI Standard Scores	1,2,3	90.0	(13.5)	**89.3**	26	90.4	(14.6)	**91.1**	28	.23	.63	.13
Child Behavior Checklist (CBCL)												
Internalizing Score	1,2	48.6	(10.5)	**48.6**	26	48.0	(8.4)	**48.0**	28	.06	.82	**.06**
Externalizing Score	1,2	52.1	(9.0)	**51.3**	26	48.5	(9.3)	**49.4**	28	.57	.45	**.21**
Total	1,2	53.6	(10.0)	**53.4**	26	49.1	(9.2)	**49.3**	28	2.21	.14	**.41**
78-MONTH Reassessment (#6)												
Age in Months at Reassessment #6*		78.4	(.7)		24	79.0	(2.3)		24	1.61	.21	**.86**
Woodcock-Johnson												
Weighted Raw Scores for:												
Broad Knowledge Total	1,2,4	462.7	(23.2)	**461.0**	25	468.8	(17.5)	**470.5**	24	3.61	.06	**.41**
Skills Knowledge Total	1,2,4	409.2	(71.4)	**406.8**	25	420.5	(33.6)	**423.0**	24	.97	.33	**.23**
Scales of Independent Behavior (SIB) Raw Scores:												
Motor	1,2	456.0	(43.6)	**452.9**	24	465.7	(18.8)	**468.8**	24	3.08	.09	**.37**
Social/Communication	1,2	462.4	(34.7)	**459.6**	24	468.5	(12.4)	**471.4**	24	3.0	.09	**.34**
Personal Living	1,2	470.0	(26.9)	**467.9**	24	472.3	(17.9)	**474.5**	24	1.26	.27	**.25**
Community Living	1,2	446.0	(30.4)	**443.8**	24	450.5	(24.4)	**452.7**	24	1.46	.23	**.29**
Total	1,2	457.6	(31.2)	**455.2**	24	461.0	(16.8)	**463.4**	24	1.46	.23	**.26**
Pictorial Scales of Perceived Competence/Social Acceptance												
Cognitive Competence	1,2	20.5	(3.1)	**20.3**	23	20.3	(3.2)	**20.4**	22	.01	.92	**.03**
Peer Acceptance	2	16.6	(5.0)	**16.5**	23	18.3	(3.2)	**19.4**	22	2.00	.17	**.38**
Physical Competence	1,2	19.8	(3.8)	**19.7**	23	19.7	(4.0)	**19.8**	21	.01	.94	**.03**
Maternal Acceptance	2	16.0	(5.7)	**16.2**	23	17.0	(4.2)	**16.9**	22	.37	.55	**.12**
Social Skills Rating System (SSRS)												
(Teacher) Standard Scores												
Total Skills'	1,2,3	91.3	(14.7)	**90.7**	23	95.0	(15.5)	**95.6**	25	1.62	.21	**.33**
Total Behavior Prob.	2,3	109.1	(12.2)	**108.8**	23	102.9	(16.1)	**103.3**	25	1.83	.18	**.45**
(Parent) standard scores												
Skills	1,2,3	92.5	(16.0)	**90.9**	21	96.6	(20.0)	**98.2**	22	1.83	.18	**.46**
Behavior Prob.	2,4	96.6	(13.1)	**97.0**	21	97.9	(15.7)	**97.0**	21	.01	.91	**.07**
Child Behavior Checklist												
Standard Score												
Internalizing	1,2,3	47.6	(9.0)	**47.4**	21	49.8	(11.5)	**50.1**	18	.60	.44	**-.30**
Externalizing	1,2	50.1	(9.7)	**49.6**	21	50.9	(9.1)	**51.4**	18	.32	.58	**-.19**
TOTAL	1,2	50.6	(10.8)	**50.2**	21	52.0	(11.1)	**52.3**	18	.34	.56	**-.19**
Developmental Test of Visual Motor Integration (VMI)												
VMI Standard Scores	1,2,3	84.7	(27.3)	**83.0**	24	90.2	(18.4)	**91.9**	24	2.29	.14	**.33**

(continued)

Table 5.14 (continued)

Comparison of Reassessment Measures on Child Functioning for Children in Delayed and Early Groups in the Salt Lake Medically Fragile Age-at-Start Study

		Delayed Intervention				Early Intervention						
	Covariates*	$\bar{X}$	(SD)	Adj. $\bar{X}$*	n	$\bar{X}$	(SD)	Adj. $\bar{X}$*	n	ANCOVA F	P Value	ES*
90-MONTH Reassessment (#7)												
Age in Months at Reassessment #7*		90.8	(2.8)		19	89.8	(2.5)		20	1.31	.26	.36
Woodcock-Johnson												
Weighted Raw Scores for:												
Broad Knowledge Total	1,2,3	479.4	(8.9)	**477.1**	18	475.5	(18.5)	**477.8**	21	.02	.88	**.08**
Skills Knowledge Total	1,2	454.3	(17.6)	**450.9**	18	448.6	31.6	**452.0**	21	.02	.90	**.06**
Scales of Independent Behavior (SIB) Raw Scores												
Motor	1,2	474.1	(21.0)	**474.1**	16	470.2	(24.4)	**470.2**	20	.22	.65	**-.19**
Social/Communication	1,2	470.3	(35.2)	**468.1**	17	475.5	(15.6)	**477.7**	20	1.25	.27	**.27**
Personal Living	1,2	471.7	(33.9)	**469.5**	17	481.0	(16.0)	**483.2**	20	2.64	.11	**.40**
Community Living	1,2	455.6	(31.2)	**454.2**	17	461.1	(15.9)	**462.5**	20	.92	.35	**.27**
Total	1,2	464.4	(37.6)	**461.4**	17	468.8	(16.6)	**471.7**	20	1.34	.25	**.27**
Pictorial Scales of Perceived Competence/Social Acceptance												
Cognitive Competence	1,2	18.0	(4.7)	**17.9**	17	19.5	(3.9)	**19.6**	20	1.29	.27	**.36**
Peer Acceptance	2	15.9	(4.8)	**16.1**	17	17.0	(4.9)	**16.8**	20	.21	.65	**.15**
Physical Competence	1,2	19.1	(3.9)	**19.0**	17	19.4	(4.3)	**19.5**	20	.15	.70	**.13**
Maternal Acceptance	2	14.6	(4.4)	**14.7**	17	14.3	(3.6)	**14.2**	20	.11	.75	**-.11**
Social Skills Rating System (SSRS)												
(Teacher) Standard Scores												
Total Skills	1,2,3,4	95.7	(14.4)	**95.7**	26	95.5	(16.2)	**95.5**	23	.00	.95	**-.01**
Total Behavior. Prob.	2,3,4	105.5	(18.9)	**105.1**	26	106.0	(16.6)	**106.0**	23	.06	.80	**-.05**
(Parent) Standard Scores												
Total Skills	1,2,3	89.8	(21.7)	**88.9**	13	102.7	(20.3)	**103.6**	18	4.18	.05	**.68**
Total Behavior Prob.	2,4	102.9	(12.1)	102.5	13	97.1	(14.2)	**97.5**	17	.91	.35	**.41**
Child Behavior Checklist												
Standard Score												
Internalizing	1,2,3	50.4	(8.6)	**50.6**	16	49.5	(10.0)	**49.5**	20	.14	.71	**.13**
Externalizing	1,2	50.1	(9.3)	**50.1**	16	49.0	(7.8)	**49.0**	20	.14	.71	**.12**
Total	1,2	53.4	(9.1)	**53.6**	16	52.0	(9.3)	**51.4**	20	.49	.49	**.24**
Developmental Test of Visual Motor Integration (VMI)												
VMI Standard Scores	1,2,3	92.4	(11.4)	**90.5**	17	85.4	(20.4)	**87.3**	21	.33	.57	**-.28**

communicative development to those provided by the BDI. Although the correlations of these scores with the BDI communication raw score were moderately high, ranging from .53 to .72 at Reassessment #3, and from .79 to .88 at Reassessment #4, the findings on the two measures of communication were inconsistent. The mean group differences were statistically significantly different on the BDI communication domain, but not on the PLS.

A measure of visual motor integration (VMI) was completed by the children at Reassessment #4, #5, #6, and #7. The VMI score correlated with the fine motor development score of the BDI (Reassessment #4, r = .32; Reassessment #5, r = .82) and with the motor weighted raw score of the SIB (r = .64) at Reassessment #6, indicating that these measures were measuring similar abilities. The scores of the early and delayed groups were not statistically significantly different on the VMI at any of the reassessments. Likewise, the two groups were not statistically significantly different on the measurement of motor development using either the BDI or SIB except for the SIB motor score at Reassessment #6. The two groups appear to be developing comparably in the areas of motor and visual-motor development.

Social development and problem behaviors were assessed by the Child Behavior Checklist (CBCL; Achenbach, 1991) and the Social Skills Rating System (SSRS; Gresham & Elliott, 1990). The CBCL was completed by a parent as Reassessment #4 and thereafter; the SSRS forms were completed by a parent and a teacher, separately, at Reassessments #6 and #7. The CBCL provides both internalizing and externalizing problem behaviors summary scores as well as a total problem behaviors score. These scores have been standardized; the standard t score is 50 with a standard deviation of 10 (Achenbach, 1991). The means for the delayed and early intervention groups were within the normal range (i.e., across reassessments they ranged from 47 to 53). However, on average, four children scored in the clinical range each year.

The SSRS provides a social skills summary score and a behavior problem score. The standard score for each is 100 and the standard deviation is 15. Higher scores on the skills domain indicates more social skills, but higher scores on the problems domain indicates more problems. Thus far, there were no statistically significant differences between the groups except one (parent rating of social skills at Reassessment #7), but not all of the children have been tested for these reassessments.

Self-concept was measured directly via the children's responses to the Pictorial Scales of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983) at Reassessments #6 and #7. The scores of the children whom the diagnostician felt did not understand the testing procedure were not included in the analyses. The authors of the measure used the domain specific approach of self-concept. Thus, four domains were measured (peer acceptance, maternal acceptance, cognitive competence, and physical competence) and no global self-concept score is given (Harter & Pike, 1984). The child, through observing pictures, rates him/herself on a Likert-scale from 1 to 4, with the higher scores indicating increased acceptance or competence. The average competence scores for the whole group were between 3.0 and 3.4; the average acceptance scores were between 2.4 and 2.9. These are a little lower than the scores of the children of the same age in the norming sample (Harter & Pike, 1983). In comparing the children in the delayed and early intervention groups, no statistically significant differences were found.

School placement also provides information about child abilities. The subjects' present school teachers completed educational services surveys in the 1992-93 and 1993-94 school years. Each year, not all parents gave us permission to contact the teachers and not all children were old enough to be in school (i.e., of at least kindergarten age) (n = 50 for each year). Approximately one-third of the subjects in the study were eligible for special education services according to the teachers' reports. These findings are comparable to those of extreme premature infants, in which 42% required special education (Msall, Buck, Rogers, & Catanzaro, 1992).

The cost-benefit study has begun to analyze the 1992-93 educational services data. The two groups differed on disability classification as defined by the federal register and on classroom placement (see Table 5.15). Disabilities (as per federal disabilities classification) were reported by the teacher for 50% of the delayed intervention group but only for 26.1% of the early intervention group. The percent of the children in regular classrooms is lower for the delayed intervention group (54.5%) than for the early intervention group (77.3%). Conversely, the percent of children in the delayed intervention group in resource and self-contained classrooms was higher than the percent of the children in the early intervention group.

Table 5.15

Disability Classification and School Placement Comparisons of the Early and Delayed Intervention Groups

	Delayed Intervention	Early Intervention
Federal Disability Classification (%)		
Specific Learning Disability	9.1	8.7
Mental Retardation	4.5	8.7
Multiple Disability	9.1	0
Hearing Impairment	9.1	0
Orthopedic Impairment	9.1	0
Other Health Impairment	9.1	8.7
Nondisabled	50.0	73.9
Classroom Placement (%)		
Regular	54.5	77.3
Resource	18.2	13.6
Self-contained	22.7	9.1
Self-contained and resource	4.5	0

The costs associated with the education of the two groups appear to be different also. For this initial educational cost analysis, local prices were not applied for the cost estimates. Instead, the estimates were based on the prices estimated by Moore, Strang, Schwartz, and Braddock (1985). These estimates included the prices estimated for educational and related services and the indirect costs associated with providing those services adjusted to 1992 dollars. The mean average dollar amounts spent were $7,357 (SD = $4,690) and $4,962 (SD = $2,922) for the delayed and early intervention groups, respectively. This difference is statistically significant, although it is based on only 42 (21 and 21) of the children for which all the necessary information was completed. The analysis of the 1993-94 school year costs will provide more insight into whether the educational costs for the two groups are indeed different. Preliminary analyses have been performed for the 1993-94 school placement data. More children in the delayed intervention group were eligible for special education and in special education classrooms then were children in the early intervention group, but the differences were not statistically significantly differenct (see Table 5.16)

Table 5.16

Comparison of Educational Placement of the Delayed Intervention and Early Intervention Groups in the Salt Lake City Medically Fragile At-at-Start Study

	Delayed Intervention		Early Intervention			
	$\bar{x}$	n*	$\bar{x}$	n*	p Value	ES
1993-94 School Year						
% Eligible for special education	37.0	27	30.4	23	.63	.12
% in special education classes	22.2	24	8.7	23	.20	.32

* This sample includes only those children who are of school age.

In sum, the child development findings are inconclusive. Early on, at Reassessments #1 and #2, the differences between the two groups in development were not statistically significant. However, differences in development emerged at Reassessments #3, #4, and #5, when the BDI total scores and some domain scores were statistically significantly higher for the early intervention group. These findings of differences were not supported by other measures of development (e.g., Stanford-Binet, Preschool Language Scale, and Developmental Test of Visual Motor Integration). At Reassessment #6, when the change in the developmental measure was implemented, the statistically significant differences between groups were found for broad knowledge (WJ-R), motor and social/communication (SIB) scores, but not for the other domain scores of the WJ-R and SIB. No group differences were found at Reassessment #7, but all the children have not yet received that assessment. Similarly, no group differences have been found on measures of social development and self-concept.

The finding of no group differences at the earlier reassessments, but some differences at the later reassessments when the children are older have been noted in other studies of similar populations (IHDP, 1990; Raugh, Achenbach, Nurcombe, Howell, & Teti, 1988). Figure 5.1 displays the wide range of the average computed BDI developmental quotients (DQ; age equivalent scores ÷ chronological age x 100) across Reassessments #1-#5. Without the one child who scored extremely low, the mean and median scores are 83.5 and 85.8, respectively. Although the computed DQ's are not standardized, they demonstrate that as a group, these children were performing at a somewhat lower level than the typical population.

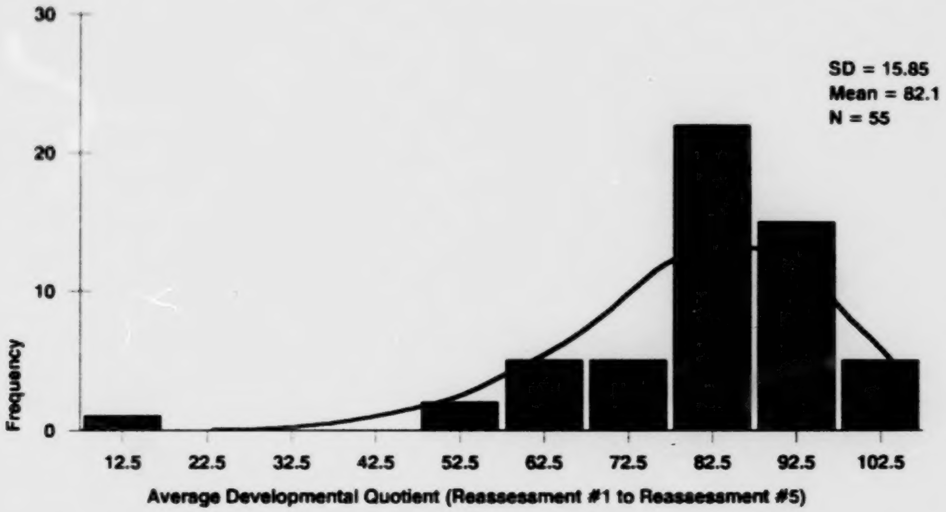

FIGURE 5.1: DISTRIBUTION OF DEVELOPMENTAL QUOTIENT (AS MEASURED BY THE BDI)

The range of the average Stanford-Binet IQ scores (computed across Reassessments #2-5) is also wide (see Figure 5.2), but the average mean and median of 94.8 and 96.5, respectively, reveal more typical abilities. (The child with the extremely low average DQ was not in this sample either because she did not complete the Stanford-Binet screening test at any reassessment.)

The standardized WJ-R achievement scores (using the broad knowledge and skill knowledge summary scores) and the SIB measures of development (administered thus far to 39 of the children at Reassessment #7) also revealed the diversity of development within the group. For example, the broad knowledge and skills knowledge scores ranged from 41 to 126 and 23 to 130, respectively. (Again, the one child could not complete this assessment due to severity of the disabilities.) The median scores for these scales were 94 and 84, respectively.

It will be important to see how these children compare to the standardized norms of the measures as they get older. Thus far, they appear to be scoring higher on the WJ-R and SIB than they did earlier on the BDI. It is possible that they are "catching up" from the developmental deficits associated with their premature births. All but three had gestational ages of 36 weeks or less.

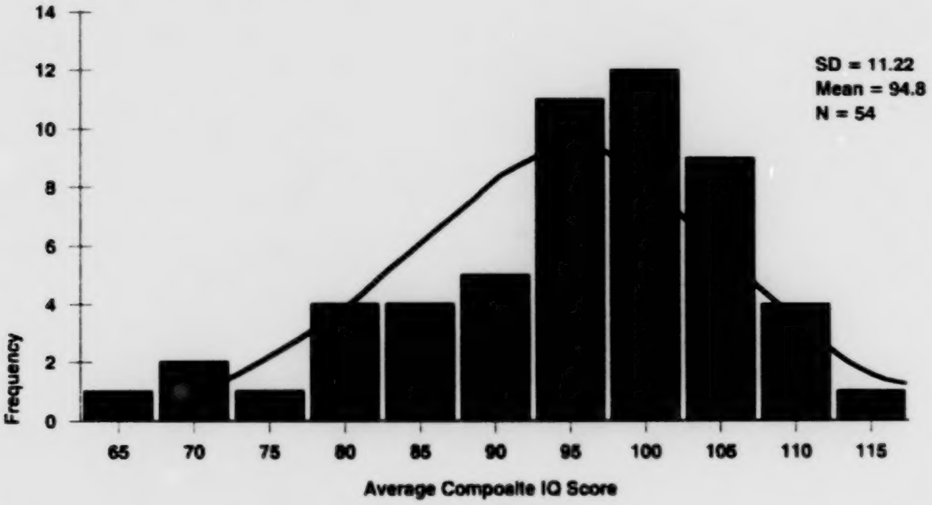

Figure 5.2: Distribution of Intelligence Quotient Scores
(as measured by the Stanford Binet Screening test)

Effects of Alternative Forms of Intervention on Measures of Family Functioning

Measures of parent interactional behaviors, parenting stress, and social support were taken at the annual reassessments. Most of the analyses were done without covariates because not all of the parents completed these family measures at the initial assessment. Therefore, the initial assessment score could not be used as a covariate because too many cases would be lost in the analyses. Other demographic characteristics did not correlate highly enough with the reassessment PSI or FSS scores to be used as covariates.

Theoretically, the intervention delivered by the physical therapist or the home visitor might have influenced the way the mother interacted with the child. It is also generally accepted that parent behaviors influence child outcomes. For these two reasons, parent-child interaction behaviors were observed and videotaped. Parent-child interaction videotapes were collected for 33 of the children when the children were 12 months of age and 44 were collected when they were 30 months of age. The 12-month videotapes were coded with the Parent/Caregiver Involvement Scale (PCIS; Farran et al., 1986) and the 30-month videotapes were coded with the Parent Behavior Rating Scale (PBRS) (Mahoney, 1988) and the P/CIS. The coding for both scales was under the direction of their respective authors.

Both the PCIS and PBRS rate the parents' interaction behaviors. The PCIS (Farran et al., 1986) scale measures three aspects of 11 parent or caregiver behaviors. The three aspects include amount of behaviors observed, the quality, and the appropriateness of the behavior. The eleven behaviors measured include: physical involvement, verbal involvement, responsiveness, play interaction, teaching behavior, control, directives, relationship among activities in which caregiver was involved, positive statements, negative statements/discipline, and goal setting. Each behavior is rated separately on a 5-point Likert-type scale, resulting in 33 rating scores. The amount, quality, and appropriateness ratings for the 11 behaviors were summed and averaged.

The PBRS (Mahoney, 1988) rates 12 aspects of parental behaviors, including warmth, expressiveness, enjoyment, acceptance, sensitivity to child's interest, responsivity, effectiveness, directiveness, achievement orientation, pace, inventiveness, and verbal praise. Based on a maximum likelihood factor analysis with oblique rotation (using the SPSSPC procedures) of these 12 variables for 237 observations of parent-child interaction from the EIRI studies, 3 factors were identified which together accounted for 59.6% of the variance. Factor 1, Affective Relationship with Child, included expressiveness toward child, warmth, enjoyment of interacting with child, inventiveness in play, and acceptance of child's behaviors. For Factor 2, Child's Interests/Responsivity, sensitivity to child's interests, responsivity, inventiveness in play, and effectiveness of parent in engaging child in play interaction were summed, and directiveness (frequency and intensity of directives) was subtracted. Factor 3, Performance Orientation, included achievement orientation, pace of parent's behaviors, verbal praise, and intensity and frequency of directiveness.

The two groups appeared to be very similar across the two assessments (see Table 5.17). No statistical differences were seen in the parent behaviors as coded by either system. The 12-month assessment provided a between group comparison of mothers who were participating in intervention with the physical therapist and those who were not; while at the 30-month assessment, all mothers were receiving the home visits with the CAMS program. A difference at the 12-month assessment, but not at the 30-month assessment, might have been expected, but there was none. Since parent interaction behaviors are linked with child development outcomes (Ainsworth et al., 1978; Belsky & Isabella, 1988), these ratings may be used in future analyses as independent variables or as covariates.

Although the intervention was not specifically focused on the parent's perceptions of social support or parenting stress, it seems plausible that with provision of services by the physical therapist, with the parent watching, and the interaction and setting of goals with the home visitor after the child was 18 months of age, the mother's parenting stress might decrease and her perception of social

Table 5.17

Comparison of Reassessment Measures of Family Functioning of Delayed Intervention and Early Intervention Groups in the Salt Lake Medically Fragile Age-at-Start Study

		Delayed Intervention					Early Intervention							
Variable	Covariates[¹]	$\bar{x}$	(SD)	Adj.$\bar{x}$[•]	%ile	n	$\bar{x}$	(SD)	Adj.$\bar{x}$[•]	%ile	n	ANCOVA F	p Value	ES[*]
12-MONTH REASSESSMENT														
• **Parent Caregiver Interaction Scale (Farran)**(average ratings) Amount:														
Quality	0,1	3.8	(.7)	**3.8**		17	3.8	(.7)	**3.7**		16	.18	.67	**-.14**
Appropriateness	0,1	3.7	(.6)	**3.7**		17	3.6	(.6)	**3.6**		16	.31	.58	**-.17**
18-MONTH Reassessment (#1)														
• **Parent Stress Index**[◆]														
Child Related		**102.3**	(13.3)		61	28	**100.5**	(15.6)		57	29	.35	.56	**.14**
Other		**129.1**	(29.8)		63	28	**121.2**	(22.8)		52	29	.99	.33	**.22**
• **Family Support Scale**[▲] **(FSS)**		**29.3**	(7.2)		56	28	**31.6**	(13.1)		66	27	.67	.42	**.32**
30-MONTH Reassessment (#2)														
• **Parent Stress Index**[◆]														
Child Related		**102.3**	(16.8)		60	27	**100.2**	(20.4)		55	29	.17	.68	**.12**
Other		**129.0**	(22.8)		65	27	**119.5**	(24.2)		48	29	2.29	.14	**.42**
• **Family Support Scale**[▲] **(FSS)**		**29.4**	(10.1)		57	27	**31.4**	(11.2)		64	29	.46	.50	**.19**
• **Parent Behavior Rating Scale (Mahoney)**														
Affective relationship	0	3.3	(.7)	**3.3**		26	3.1	(.7)	**3.1**		25	.66	.42	**-.29**
Child Orientation	1	3.5	(.4)	**3.5**		26	3.4	(.7)	**3.4**		24	.29	.59	**-.25**
Performance Orientation	2	3.2	(.6)	**3.2**		26	3.2	(.7)	**3.2**		24	.01	.94	**.00**
• **Parent/Caregiver Interaction Scale (Farran)** Average Rating:														
Quality	0,1	3.1	(.5)	**3.1**		25	3.1	(.9)	**3.1**		25		.81	**.10**
Appropriateness	0,1	3.1	(.6)	**3.2**		25	3.5	(1.3)	**3.4**		25		.50	**.33**
42-MONTH Reassessment (#3)														
• **Parent Stress Index**[◆]														
Child Related		**104.9**	(18.9)		65	27	**102.2**	(16.3)		60	28	.32	.57	**.14**
Other		**125.8**	(24.9)		60	27	**127.3**	(25.4)		61	28	.05	.83	**-.04**
• **Family Support Scale**[▲] **(FSS)**		**29.0**	(10.6)		55	27	**31.0**	(10.5)		63	28	.51	.48	**.19**
54-MONTH Reassessment (#4)														
• **Parent Stress Index**[◆]														
Child Related		**108.9**	(23.8)		74	26	**100.8**	(21.0)		57	25	1.66	.20	**.34**
Other		**127.6**	(20.7)		63	26	**124.3**	(28.3)		56	25	.23	.63	**.16**
• **Family Support Scale**[▲] **(FSS)**		**31.5**	(10.9)		67	27	**31.7**	(9.8)		67	26	.01	.94	**.02**

(continued)

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[*] $ES = \frac{\text{Early Intervention Adj.}\bar{x} - \text{Delayed Intervention Adj. }\bar{x}}{\text{Delayed Intervention SD}}$ Negative ES indicate that the early intervention group is doing less well than the delayed intervention group.

[•] Covariance adjusted means

[◆] Analysis for the PSI are based on raw scores. Lower scores are considered better. Both scales provide norms. High percentiles on the PSI represent more stress. Scores can range from 47 to 235 on the child-related scale and 54 to 270 on the other stress scale.

[▲] Analyses for the FSS is based on raw scores indicating number of supports or resources indicated by the family as being available. Scores can range from.....Higher scores and positive ESs are considered better. No norming sample is reported for this measure. To assist with interpretation, a percentile score is reported in the table based on all assessments collected as a part of the Longitudinal Studies (currently, 854 families with children with disabilities).

[¹] 0 = total income; 1 = Days of care in NICU; 2 = Grade of IVH. If no covariates are listed, none were found that moderately correlated with the measure, or not enough subjects completed the measure.

Table 5.17 (continued)

Comparison of Reassessment Measures of Family Functioning of Delayed Intervention and Early Intervention Groups in the Salt Lake Medically Fragile Age-at-Start Study

Variable	Covariates'	Delayed Intervention					Early Intervention					ANCOVA	p	
		$\bar{x}$	(SD)	Adj. $\bar{x}$'	%ile	n	$\bar{x}$	(SD)	Adj. $\bar{x}$'	%ile	n	F	Value	ES*
66-MONTH Reassessment (#5)														
• **Parent Stress Index (Short Form)***														
Parent Distress		**24.9**	(7.7)		50	25	**26.8**	(7.1)		60	27	.86	.36	**.25**
Parent-Child Interaction		**27.2**	(6.8)		90	25	**26.9**	(5.6)		90	27	.05	.82	**-.04**
Difficult Child		**30.5**	(8.5)		77	25	**29.0**	(7.1)		70	27	.49	.49	**-.18**
• **Family Support Scale' (FSS)**		**32.8**	(10.9)		69	26	**29.5**	(10.8)		59	26	1.18	.28	**-.30**
78-MONTH Reassessment (#6)														
• **Parent Stress Index (Short Form)***														
Parent Distress		**24.2**	(8.3)		40	25	**25.5**	(8.6)		53	23	.29	.59	**.16**
Parent-Child Interaction		**20.9**	(5.4)		60	25	**21.5**	(7.9)		62	23	.08	.77	**-.11**
Difficult Child		**27.4**	(6.5)		60	25	**27.6**	(7.8)		63	23	.00	.95	**.03**
• **Family Support Scale (FSS)**		**33.0**	(11.5)		69	24	**29.7**	(8.9)		59	22	1.13	.29	**-.29**
90-MONTH Reassessment (#7)														
• **Parent Stress Index (Short Form)***														
Parent Distress		**25.1**	(6.9)		50	15	**23.1**	(8.4)		35	19	.53	.47	**-.29**
Parent-Child Interaction		**21.2**	(5.4)		60	15	**22.6**	(8.0)		67	19	.35	.56	**.26**
Difficult Child		**28.7**	(4.8)		70	15	**25.6**	(9.2)		53	19	1.34	.26	**-.65**
• **Family Support Scale (FSS)**		**24.9**	(9.3)		42	17	**30.7**	(11.6)		63	20	2.71	.11	**.62**

support might increase. Results of the ANCOVA did not support either of these assumptions. No significant differences between the early and delayed intervention groups on family support were found at any of the reassessments (see Table 5.17).

Similarly, no significant statistical group differences were found at any of the reassessments on measures of parenting stress, with either the stress due to caring for the child or in other aspects of the parents' lives. The percentile scores indicate that the average stress of both groups was within the normal range, except for part of the parent-child interaction and difficult child stress scores at Reassessment #5.

Other Analyses

Videotaped assessment of motor functioning. A videotaped procedure was used to capture spontaneous motor behavior in 12-month-old infants. The protocol for the sequences encouraged the infant to perform a series of 13 movement patterns which are typically attained during the first year of life. Included in the movement patterns elicited were rolling over, crawling, sitting up, pulling to stand, cruising, walking, squatting, and reaching, among others. The infant's performance was rated using a three-point rating scale which assessed qualities of movement patterns such as weight shift, balance, coordination, reflex integration, body alignment, symmetry, and trunk rotation.

Twenty-seven infants were assessed with the Videotaped Assessment of Motor Functioning at 12 months CCA. These were rated using the Motor Sequence Rating Scale (Peterson & Miller, 1985). The total score of the motor rating was correlated with the BDI fine motor, gross motor, motor total, and cognitive subdomain scores from the reassessments at 18 and 30 months CCA. All the correlations were statistically significantly high, especially for the gross motor scores (see Table 5.18).

Because this assessment was being developed, not all the videotapes were adequate to be scored with the rating system. Twenty-seven of the tapes were usable and these did not happen to be equally divided between the early and delayed intervention groups (Early intervention group = 17, delayed intervention group = 10). Therefore, the motor functioning of the early intervention and the delayed intervention groups was not compared.

Table 5.18

Correlations of Battelle Developmental Inventory Raw Scores with Videotaped Motor Ratings at 18 and 30 Months Corrected Chronological Age for the Salt Lake City Medically Fragile Age-at-Start Study

	18 Month CCA			30 Month CCA		
Variable	r	p	n	r	p	n
Fine Motor	.69	.00	27	.71	.00	24
Gross Motor	.89	.00	27	.91	.00	24
Motor Total	.85	.00	27	.87	.00	24
Cognitive	.59	.00	27	.63	.00	24
TOTAL	.63	.00	27	.70	.00	24

Birth characteristics as predictors of child development outcome. Within the research field concerned with the effectiveness of early intervention for medically fragile infants, there remains an overwhelming need for earlier and more accurate predictors of developmental outcomes (Bennett, 1987). Casto (1992) developed the Medical Status Index (MSI), in which certain neonatal risk factors and birth characteristics are rated as to their severity on a 1-3-5 point scale. The factors rated included days on ventilator, respiratory status, days hospitalized, neurological status, sensory status, birthweight, and medical complications. The possible range of the total scores was 7 to 35, with higher scores indicating more severe conditions. The mean score for this sample was 17.41, with a range of 7.7 to 33. A median split analysis was performed with a t-test procedure, and the group (n = 27) with the less severe medical index scores scored statistically significantly better (p = .04) than did the group (n = 31) with the more severe index scores on the BDI at Reassessment #1.

Correlational analyses were performed using seven-item and total scores of the MSI and other measures of birth and neonatal risk with the child developmental outcomes at the 66-month assessment. The purpose was to investigate which of these measures of birth characteristics and neonatal risk factors best predicted child development 5½ years later. The three variables with the highest overall correlations were (a) number of days spent in the Neonatal Intensive Care Unit (NICU), (b) the degree of sensory impairment as measured by that item in the MSI, and (c) the degree of neurological damage (also measured by MSI) (refer to Table 5.19). The total score of the MSI also correlated statistically significantly with the child development scores, but not as highly. These variables were much more salient than variables that are more often used in research and practice (e.g., birthweight, gestational age, and APGAR scores). Others concur with these findings (e.g., Richardson, Gray, McCormick, Workman, & Goldman, 1993).

Table 5.19

Bivariate Correlations of Developmental Outcome at 66 Months and Birth Data

Birth Data	Birth Data $\bar{x}$	Birth Data SD	BDI Raw Scores Personal/ Social	BDI Raw Scores Adaptive Behavior	BDI Raw Scores Motor	BDI Raw Scores Communication	BDI Raw Scores Cognitive	BDI Raw Scores TOTAL
Birthweight	1410	620	.11	.14	.17	.12	.12	.13
Gestational age	30	3.2	.16	.18	.20	.12	.11	.16
APGAR (5 minute)	6.1	1.8	.01	.08	.24*	.06	.10	.11
Grade of IVH	2.2	1.1	-.15	-.19	-.35**	-.15	-.24*	-.25*
Days in NICU	31	31	-.35**	-.29*	-.27*	-.31*	-.39**	-.34**
Respiratory distress(%)	10		-.21	-.21	-.22	-.20	-.23	-.23
Seizure disorder(%)	12		-.36**	-.32*	-.22	-.31*	-.25*	-.31*
Lumbar puncture(%)	45		-.20	-.22	-.19	-.24*	-.23	-.22
Medical Status Index Total[a]	17.4	7.7	-.24	-.22	-.23	-.20	-.25*	-.23
Neurological status[b]	2.0	1.5	-.26*	-.33*	-.45***	-.24*'	-.35**	-.36**
Sensory status[c]	1.3	.8	-.42***	-.39**	-.26*	-.32*	-.29*	-.36**
Category of weight	2.0	1.5	-.20	-.17	-.16	-.17	-.16	-.17
Days on ventilator	2.3	1.9	-.24*'	-.18	-.15	-.18	-.25*	-.20
Days hospitalized	3.5	1.5	-.18	-.16	-.11	-.17	-.18	-.15

* $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$

Note: [a] Total score on the Medical Status Index (MSI; Casto, 1992)
[b] Degree of neurological damage, as indicated by neuro exam and grade of IVH; this and the following four are items on the MSI
[c] Stage of ROP and degree of hearing deficit

$\bar{x}$ = mean

SD = Standard Deviation

Intervention intensity comparison. Perhaps the group comparison (early vs delayed intervention groups) did not provide an adequate test of the difference in beginning intervention at three versus 18 months, given that all of the children in the early intervention group did not receive the prescribed frequency of intervention. Hence it seemed appropriate to compare a group who had received the desired frequency of early intervention with a group who received the later intervention. Only subjects living in the Salt Lake area during the 3 to 18 month period were included in this analysis because they received the intervention from the EIRI service providers, and were more likely to receive the amount and kind of intervention intended. Eighteen children in the early intervention group who had received 11 or more intervention sessions between the ages of 3 and 10 months, and were identified. Sixteen children in the delayed intervention group were also identified. T-test analyses of these two groups on family demographic and child birth characteristics were completed to see if the two groups were initially comparable. The two groups were found to be comparable on all the demographic characteristics, but they differed substantially on certain birth characteristics. The characteristics that the two groups differed on included birthweight (p = .01), gestational age (p = .02), number of transfusions (p = .04), Medical Status Index total score (p = .03), and number of days in intensive care (NICU) (p = .01) with the children in the comparison group having the advantage. The number of covariates used in the analysis was limited to one (days in NICU) because of the small sample size. At reassessments #1 and #2 there were no statistically significant differences on measures of child development, family support, or parenting stress between the groups who had received the recommended amount of early intervention and the delayed intervention group. However, at Reassessments #3 and #4 the early intervention group scored significantly higher on total BDI and some of the subdomains than did the delayed intervention group (refer to Table 5.20). At Reassessment #5, no differences were found in BDI scores and the testing is not completed for Reassessments #6 and

#7. The purpose of this analysis was to more specifically test the age-at-start question by controlling the intensity (amount) of intervention provided. A clearer effect in favor of the group receiving the earlier intervention was not found.

Children's present health conditions. In the Spring of 1993, the 55 families who are involved in the study participated in a telephone survey. One questionnaire used in the interviews dealt with the children's present health conditions. The infants in this study were considered "at risk" of developing a number of disabilities. The purpose of the survey, therefore, was to define the health conditions or disabilities that were evident by the time the children were beginning public school. The mean age of the children at the time of the survey was 7 years of age, ranging from almost 5 years of age to almost 8½ years of age. Most of the respondents were mothers, but six fathers and one grandparent (who was the primary caregiver) participated in the survey. The questionnaire dealt with 12 specific conditions by asking two questions: (1) had a physician or school official told them their child had that condition, and (2) did they think their child had that condition (see Table 5.21 for a listing of conditions).

The close agreement between the parent's report of professional opinion and their own opinion is noteworthy. The one exception is attention problems. The diagnosis of attention problems usually occurs when children are in the primary grades; the children are still in this age period.

A variety of health- and behavior-related problems were reported. According to the professional opinion, 25% of the children had some kind of visual impairments; the majority of these appear to be corrected with glasses. Hearing and communication problems were less common (9% and 16%, respectively). Nine of the children (16%) had been diagnosed as having cerebral palsy, and several others demonstrated either fine or gross motor problems. The fact that motor problems occurred this frequently is consistent with similar research conducted elsewhere (Msall et al., 1992). Five children (9%) were reported as intellectually disabled.

Table 5.20

Comparison of Measures on Child and Family Functioning for Children Receiving 11 or More Intervention Sessions During Early Intervention Period and Children in Delayed Group*

		Delayed Intervention				Early Intervention						
Variables	Covariates*	$\bar{x}$	(SD)	Adj. $\bar{x}$*	n	$\bar{x}$	(SD)	Adj. $\bar{x}$*	n	ANCOVA F	P Value	ES*
18-MONTH REASSESSMENT (#1)												
Battelle Developmental Inventory (BDI) (raw scores)												
Personal/Social	1,2	57.7	(13.9)	**54.5**	16	53.8	(15.5)	**57.0**	18	.25	.62	**.18**
Adaptive behavior	1,2	40.8	(7.1)	**38.9**	16	40.3	(11.0)	**42.2**	18	1.05	.31	**.47**
Motor	1,2	59.3	(15.8)	**56.2**	16	58.7	(18.4)	**61.9**	18	.88	.36	**.36**
Communication	1,2	30.8	(4.4)	**29.3**	16	27.8	(7.5)	**29.2**	18	.00	.96	**.02**
Cognitive	1,2	21.9	(3.1)	**21.0**	16	21.3	(5.0)	**22.2**	18	.66	.42	**.39**
TOTAL	1,2	210.5	(35.2)	**200.0**	16	201.9	(52.1)	**212.5**	18	.72	.40	**.36**
PARENTING STRESS INDEX (PSI)												
Child Related	1	105.8	(14.2)	**106.2**	16	103.8	(11.6)	**103.3**	17	.34	.57	**.20**
Other	1	128.0	(34.2)	**126.6**	16	123.3	(17.0)	**124.6**	17	.04	.85	**.05**
FAMILY SUPPORT SCALE (FSS)	1	29.1	(7.1)	**29.8**	16	34.5	(11.0)	**33.7**	15	1.18	.29	**.55**
30-MONTH REASSESSMENT (#2)												
Battelle Developmental Inventory (BDI) (raw scores)												
Personal/Social	1	83.9	(18.5)	**80.8**	16	84.7	(28.7)	**87.8**	18	.63	.44	**.38**
Adaptive Behavior	1	55.0	(9.6)	**52.4**	16	55.6	(18.2)	**58.2**	18	1.23	.28	**.60**
Motor	1	79.2	(16.1)	**76.1**	16	77.7	(21.8)	**80.9**	18	.46	.51	**.30**
Communication	1	40.8	(7.9)	**39.2**	16	39.7	(11.6)	**41.3**	18	.35	.56	**.27**
Cognitive	1	30.8	(6.3)	**29.4**	16	28.9	(8.4)	**30.3**	18	.11	.74	**.14**
Total	1	289.7	(46.2)	**277.9**	16	286.6	(81.6)	**298.4**	18	.74	.40	**.44**
Parenting Stress Index												
Child Related	1	104.9	(18.6)	**106.4**	16	104.8	(20.2)	**103.3**	18	.18	.68	**.17**
Other	1	127.3	(24.1)	**126.1**	16	122.3	(22.5)	**123.4**	18	.10	.78	**.11**
Family Support Scale (FSS)	1	30.3	(10.5)	31.7	16	33.7	(9.7)	32.2	18	.01	.91	.05
42-MONTH REASSESSMENT (#3)												
Battelle Developmental Inventory (BDI) (raw scores)												
Raw Scores for:												
Personal/Social	1	103.9	(22.8)	**102.1**	16	102.0	(31.1)	**103.8**	17	.03	.87	**.08**
Adaptive Behavior	1	67.5	(13.9)	**65.4**	16	71.7	(12.5)	**73.8**	17	3.19	.08	**.60**
Motor	1	90.3	(19.9)	**84.4**	16	92.4	(15.5)	**94.3**	17	.81	.38	**.30**
Communication	1	54.3	(16.6)	**52.3**	16	57.6	(10.8)	**60.3**	17	2.95	.10	**.48**
Cognitive	1	40.6	(9.6)	**39.1**	16	43.7	(7.4)	**45.2**	17	4.09	.05	**.64**
Total	1	356.6	(70.1)	**345.7**	16	372.4	(53.9)	**383.5**	17	2.98	.10	**.54**
Parenting Stress Index (PSI)												
Child Related	1	106.5	(17.1)	**107.5**	15	102.2	(14.6)	**101.2**	17	1.05	.31	**.37**
Other	1	130.1	(27.4)	**129.2**	15	126.6	(27.5)	**127.5**	17	.12	.73	**.06**
Family Support Scale (FSS)	1	29.0	(12.8)	**29.6**	15	33.6	(8.7)	**33.0**	17	.65	.43	**.27**

(continued)

* This group contains only those children in the delayed group who remained in the same geographical area for the 18-month time period.

* Covariance adjusted means.

* Covariates: 1 = Days of care in NICU, 2 = Education of Father, 3 = Age of Mother, 4 = Education of Mother

$$\text{ES} = \frac{\text{Early Intervention with 11 or more adj. } \bar{x} - \text{Delayed Intervention adj. } \bar{x}}{\text{Delayed Intervention SD}}$$

Negative ES indicates that the early intervention group is doing less well than the delayed intervention group.

Table 5.20 (continued)

Comparison of Measures on Child and Family Functioning for Children Receiving 11 or More Intervention Sessions During Early Intervention Period and Children in Delayed Group*

		Delayed Intervention				Early Intervention						
Variables	Covariates*	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	ANCOVA F	P Value	ES
54-MONTH REASSESSMENT (#4)												
Battelle Developmental Inventory (BDI) (raw scores)												
Personal/Social	1,2	116.3	(28.9)	**112.8**	16	120.6	(22.9)	**124.1**	16	1.45	.24	**.39**
Adaptive Behavior	1,2	76.3	(16.8)	**74.1**	16	79.9	(13.8)	**82.1**	16	2.53	.12	**.68**
Motor	1,2	101.3	(26.6)	**100.1**	16	107.3	(19.2)	**108.4**	16	1.01	.33	**.31**
Communication	1,2	66.6	(18.6)	**63.3**	16	73.7	(15.2)	**76.9**	16	6.59	.02	**.73**
Cognitive	1,2	53.1	(16.1)	**51.6**	16	56.8	(13.7)	**58.3**	16	2.30	.14	**.42**
Total	1,2	413.7	(96.3)	**402.1**	16	438.3	(70.8)	**449.9**	16	3.15	.09	**.50**
Parenting Stress Index (PSI)												
Child Related	1	111.1	(27.3)	**115.4**	14	103.9	(20.2)	**99.7**	16	3.22	.08	**.58**
Other	1,3,4	127.9	(24.5)	**128.1**	14	126.9	(24.5)	**126.8**	16	.02	.88	**.05**
Family Support Scale (FSS)	1	28.5	(9.1)	**28.6**	15	33.1	(9.0)	**33.0**	16	1.47	.24	**.48**
66-MONTH REASSESSMENT (#5)												
Battelle Developmental Inventory (BDI) (raw scores)												
Personal/Social	1,2	143.1	(15.3)	**139.8**	15	144.2	(22.4)	**145.5**	16	1.13	.30	**.37**
Adaptive Behavior	1,2	89.2	(12.9)	**87.9**	15	91.9	(14.5)	**93.2**	16	.92	.35	**.41**
Motor	1,2	126.1	(25.5)	**124.8**	16	128.5	(23.3)	**129.8**	16	.27	.61	**.20**
Communication	1,2	86.9	(15.9)	**84.4**	15	86.4	(16.2)	**89.0**	16	.70	.41	**.29**
Cognitive	1,2	79.9	(13.2)	**76.7**	15	77.6	(15.3)	**80.6**	16	.72	.40	**.29**
Total	1,2	521.2	(71.1)	**510.5**	15	528.7	(81.3)	**539.4**	16	1.14	.30	**.41**
Parenting Stress Index (SF)												
Parent Distress	1	24.4	(9.3)	**25.0**	13	26.0	(6.2)	**25.4**	17	.01	.91	**-.04**
Parent/Child Int.	1	25.6	(6.8)	**26.3**	13	26.2	(5.6)	**25.5**	17	.12	.73	**.12**
Difficult Child	1	32.1	(6.9)	**32.5**	13	30.9	(5.5)	**30.1**	17	.59	.45	**.35**
Family Support Scale (FSS)	1	30.1	(8.7)	**29.2**	14	32.3	(9.7)	**33.3**	15	1.10	.30	**.47**
78-MONTH REASSESSMENT (#6)												
Woodcock-Johnson--Revised (standard scores)												
Broad Knowledge	1	464.5	(13.1)	**461.2**	14	471.1	(17.7)	**474.5**	15	5.16	.03	**1.02**
Skills Total	1	405.3	(86.6)	**400.1**	14	417.9	(36.8)	**423.1**	15	.71	.41	**.27**
Scales of Independent Beh. (standard scores)												
Motor	1	459.2	(23.6)	**455.5**	13	465.5	(23.0)	**469.2**	15	2.02	.17	**.58**
Social/Communication	1	461.9	(26.6)	**458.9**	13	466.9	(15.0)	**469.8**	15	1.51	.23	**.41**
Personal Living	1	471.6	(10.5)	**467.0**	13	472.7	(21.4)	**477.3**	15	2.56	.12	**.98**
Community Living	1	447.5	(16.9)	**442.5**	13	448.0	(29.4)	**453.0**	15	1.17	.29	**.62**
Total	1	458.1	(12.7)	**454.5**	13	461.8	(18.7)	**465.4**	15	23.90	.10	**.86**
Parent Stress Index (SF)												
Parent Distress	1	25.8	(9.7)	**24.7**	14	25.9	(8.0)	**27.0**	14	.42	.52	**-.24**
Parent/Child Int.	1	21.6	(4.6)	**21.6**	14	23.2	(8.3)	**23.2**	14	.33	.57	**-.35**
Difficult Child	1	29.4	(6.2)	**29.3**	14	29.6	(7.9)	**29.7**	14	.01	.92	**-.07**
Family Social Support (FSS)	1	28.6	(7.8)	**29.4**	13	32.2	(8.8)	**31.4**	13	.29	.60	**.26**
90-MONTH REASSESSMENT (#7)												
Woodcock-Johnson--Revised (standard scores)												
Broad Knowledge	1	478.3	(10.1)	**473.4**	10	473.9	(22.0)	**478.8**	13	.61	.45	**.54**
Skills Total	1	455.6	(15.9)	**447.9**	10	442.2	(36.0)	**449.9**	13	.03	.87	**.13**
Scales of Independent Beh. (standard scores)												
Motor	1	468.7	(25.7)	**468.3**	9	469.7	(28.9)	**470.1**	13	.02	.89	**.07**
Social/Communication	1	478.9	(14.2)	**475.9**	9	475.2	(18.7)	**478.2**	13	.09	.76	**.16**
Personal Living	1	477.0	(18.4)	**475.0**	9	479.5	(18.4)	**481.6**	13	.59	.45	**.36**
Community Living	1	459.9	(9.1)	**459.3**	9	461.2	(21.7)	**461.9**	13	.09	.77	**.29**
Total	1	471.1	(10.2)	**467.4**	9	465.9	(19.4)	**469.6**	13	.10	.75	**.22**
Parent Stress Index (SF)												
Parent Distress	1	24.1	(7.5)	**24.7**	9	24.2	(6.4)	**23.6**	12	.10	.75	**.15**
Parent/Child Int.	1	19.8	(4.8)	**20.4**	9	22.2	(8.0)	**21.6**	12	.14	.72	**-.25**
Difficult Child	1	29.0	(5.5)	**29.5**	9	26.5	(9.0)	**26.0**	12	.84	.37	**.64**
Family Social Support (FSS)	1	25.0	(9.9)	**24.3**	10	33.0	(10.0)	**33.7**	13	4.03	.06	**.95**

(refer to previous page for legend)

Table 5.21

Survey of Health/Behavioral Conditions: Spring, 1993

Variable	According to Doctor/School			According to Parent		
	No (%)	Yes (%)	Maybe (%)	No (%)	Yes (%)	Maybe (%)
Vision Problems	71	25	4	71	25	4
Hearing Problems	91	9	0	89	4	4
Communication Problems	84	16	0	86	14	0
Visual/Motor Problems	76	22	2	74	24	2
Orthopedic Problems	80	20	0	78	22	0
Attention Problems	76	18	6	69	25	6
Behavioral Problems	89	6	5	87	7	6
Learning Problems	89	4	7	85	6	9
Intellectual Disability	89	9	2	89	7	4
Seizures	93	5	2	93	5	2
Cerebral Palsy	84	16	0	84	16	0
Heart Condition	93	2	5	94	2	4

n = 55, $\bar{x}$ child age = 7 years, range = 4 years 9 months to 8 years 5 months

Respondents (%): Mother 85%, Father 13%, Grandparent 2%

The incidence of attention problems, although no yet well established, appears to be high. Approximately 1/4 (professional opinion = 24%; parent opinion = 31%) of the children may suffer from the inability to attend (i.e., attention deficit hyperactivity disorder [ADD or ADHD]). The national average for children with attention problems is approximately 5% (HADD National Educational Committee, 1992.).

Three children were experiencing seizures and one had a heart condition. These conditions had been experienced by more children when they were younger, but they were either no longer having problems or the parents had been advised that the condition was no longer a concern.

Overall, there appear to be large differences in the present level of functioning across this group of children. Almost 40% did not have any of the reported conditions. Among the 62% for whom one or more conditions were reported, it appears that a few of the children accounted for the majority of the problems reported. In a similar longitudinal study of premature infants (Msall et al., 1992), 63% had one or more minor impairments, while 22% had major neurodevelopmental impairments.

To verify the relationships between present disabilities and neonatal characteristics, group mean comparisons were conducted. Groups with particular conditions (e.g., cerebral palsy, intellectual disability, attention problems) as well as those children who presently have no health conditions (i.e., presently are healthy) were examined as to grade of IVH, birthweight, gestational age, and days in intensive care. See Table 5.22 for a comparison of grade of IVH, birthweight, gestational age, and days in intensive care of children who have certain health conditions with the total group and with the group for whom no present health problems were reported.

Table 5.22

Neonatal Characteristics of Children with Specific Health Conditions and Disabilities

	Total Sample (n=55)	Cerebral Palsy (n=9)	Intellectually Disabled (n=6)	Attention Problems (n=13)	Vision Problems (n=16)	Eligible˙ for Spec. Education (n=15)	Healthy• (n=21)
Grade of IVH (%)							
1	34.5	22.2▲	33.3	38.5	31.3	26.7▲	38▲
2	30.9	11.1		38.5	18.7	13.3	48
3	20.0	22.2	16.7	15.4	31.3	26.7	14
4	14.5	44.4	50.0	7.7	18.7	33.3	0
Birthweight $\bar{X}$	1407.7	1162.2*	1180.0	1473.5	1447.8	1220.0*	1413.1
Gestational Age $\bar{X}$	30.0	28.4	28.7	30.5	30.8	29.5	29.9
Days in Intensive Care $\bar{X}$	30.6	27.7	61.8*	33.0	41.3	44.1	19.7

˙ eligibility for special education was reported via teacher questionnaire.

• These children experienced none of the conditions assessed, and their parents indicated they were developing normally.

▲ Distribution for these conditions were statistically significantly different; chi square alpha ≤ .05

* p value ≤ .05

Predictors of problem behaviors. The incidence and correlates of behavior problems were investigated with this sample. Two sets of analyses were performed. Preassessment variables, including the neonatal characteristics, medical problems, demographic characteristics, and 6-month temperament scores were correlated with the measures of child behavior problems, assessed when the children were 4½ years of age. contemporaneous correlations (i.e., all measures were taken at the same time) were also analyzed comparing child temperament and development scores, and family demographic and perceptions of well-being with the child behavior problem scores. Fifty-two children had all the necessary assessments to be included in the present analyses.

Child behavior problems were measured with the CBCL. The CBCL is completed by a parent (in this study, almost always by the mother). Responses are grouped into eight categories (e.g., withdrawn, anxious/depressed, social problems). These categories are combined to form the internalizing and externalizing subscales. The standardized t scores of these two subscales were used in the analyses. The CBCL is perhaps the most widely used measure of child behavior in the United States and evidence of its reliability and validity has been reported across multiple studies.

Temperament was measured during infancy with the Infant Temperament Questionnaire--Revised (Carey & McDevitt, 1977) and at 54 months of age with the Behavioral Style Questionnaire (McDevitt & Carey, 1975). Both scales provide parent ratings of nine aspects of the child's temperament, and on temperament clusters (e.g., easy, difficult, slow-to-warm) which follow the N.Y.L.S. model by Thomas and Chess (1970). Information concerning the reliability and validity of the instruments is provided by the authors (Carey & McDevitt, 1978; McDevitt & Carey, 1978), and is reviewed by Seifer and Samaroff (1986). Other researchers have derived a composite difficulty score from the rhythmicity, approach, adaptability, intensity, and mood scales and have found it to be stable; the individual category of activity has also shown frequent stability (Seifer & Samaroff, 1986). Hence, the present study used a composite difficulty score (combining the rhythmicity, approach, adaptability, intensity, and mood scales) and the activity score in the analyses.

The outcome or dependent variables for this investigation were the child behavior problems (i.e., the internalizing and externalizing CBCL subscales) the children exhibited when they were 4½ years of age. The independent variables included indices of neonatal medical problems, child development and temperament, family demographic characteristics, and perceptions of family functioning and stress. These independent variables were grouped into three classifications: (a) child characteristics, including neonatal characteristics, development and temperament, (b) family demographic characteristics, and (c) perceptions of family well-being (e.g., parent stress).

Initial analyses (i.e., _t_-tests) were performed comparing the two treatment groups (early intervention vs. delayed intervention) on the internalizing and externalizing problem behavior subscales of the CBCL. No group differences were found; therefore, the two treatment groups were combined into one group for the subsequent analyses.

The analyses for this study were three-fold. First, descriptive statistics for all variables were investigated. Second, bivariate correlations were analyzed for all variables. Two sets of correlation analyses were performed. The first correlated variables assessed during infancy with child behavior problems when the children were 4½ years of age. The second used a concurrent design correlating variables assessed when the children were 4 1/2 years of age. Third, a series of stepwise multiple regressions were performed for the outcome variables of internalizing and externalizing behavior problems. One group of independent variables (i.e., child characteristics, family demographic characteristics or perceptions of family functioning) was considered in each regression model, using only those variables which correlated ($\underline{r} > .20$) with either of the outcome variables. The regression analyses were performed for both the longitudinal and contemporaneous correlations. The results are reported in this sequence.

The group means for both internalizing and externalizing problem behavior subscales were within the normal range. However, 10.2% (5 boys and 1 girl) and 24.7% (10 boys and 3 girls) scored in the borderline clinical (t score of 60 to 63) or clinical range (t score of 64 or above) of the internalizing and externalizing subscales, respectively.

The longitudinal correlational analyses revealed that the neonatal characteristics and medical indices were not associated with the behavior problems when the children were 4½ years of age (see Table 5.23). Correlations between these two sets of variables were generally in the low to moderate range. Internalizing problems behaviors were mildly associated with infant development and communication abilities, and with the family characteristics of mother's education and number of parents in the home. The temperament difficulty score (i.e. the sum of the rhythmicity approach adaptability intensity , and mood scales) did not correlate significantly with internalizing behaviors, but the activity score did. Externalizing behaviors were associated with activity level and gender, and with the family characteristics of mother's age, education, and income. Maternal perceptions of well-being (i.e., stress, family social support, and resources) did not significantly correlate with later child behavior problems.

The bivariate correlations for the concurrent analyses generally were higher than they were in the longitudinal analyses. Internalizing problem behaviors were moderately associated with child temperament difficulty, development, communication abilities, and number of parents in the home (refer to Table 5.24). Externalizing problem behaviors were related to temperament difficulty, activity, number of parents in the home, and parent stress.

The regression analyses demonstrated that aspects of temperament (i.e., activity level, longitudinally, and the composite difficulty score, concurrently) were significant predictors of internalizing (see Table 5.25) and externalizing (see Table 5.26) problem behaviors. The number of parents in the home and certain parent

Table 5.23

Longitudinal Bivariate Correlations, Means, and Standard Deviations of Child Behavior Problems at 4½ Years of Age and Variable Assessed During Infancy

Variable	Internalizing Behaviors	Externalizing Behaviors	$\bar{x}$	SD
Internalizing Problem Behaviors	1.00	.70	47.7	10.1
Externalizing Problem Behaviors	.70	1.00	50.8	10.3
Child Characteristics				
Birthweight (grams)	-.02	.14	1423.0	621.7
Gestational Age (weeks)	-.03	.07	30.1	3.2
Days in Intensive Care	.03	-.02	30.4	30.3
Medical Status	.03	-.02	17.3	7.7
Gender (% girls)	-.14	-.26*	54.0	
Development	-.28*	-.12	208.5	42.5
Communication	-.19^	-.00	29.0	6.3
Temperament	-.01	.02	1433.0	204.8
Activity	.18	.28*	433.0	63.7
Family Characteristics				
Mother's Age (years)	-.09	-.21^	25.8	5.0
Mother's Education (years)	-.20^	-.21'	13.1	2.1
Annual Income ($)	-.14	-.20^	$27,254.4	417,645.6
# of Parents in Home	-.19^	-.05		
Perceptions of Family Functioning				
Parent Stress	-.04	.14	125.6	26.4
Family Support	-.02	-.04	30.4	10.5
Family Resources	-.13	-.14	126.3	20.1

* *p*-value = ≤ .05
^ *p*-value = ≤ .10

Table 5.24

Concurrent Bivariate Correlations, Means, and Standard Deviations of Variables Assessed When Children Were 4½ Years of Age

Variable	Internalizing Behaviors	Externalizing Behaviors	$\bar{x}$	SD
Behavior Problems				
Internalizing			47.7	10.1
Externalizing			50.8	10.3
Child Characteristics				
Temperament	.48*	.48*	1672.4	246.0
Activity	.18	.40*	372.6	64.7
Development	-.24*	.01	423.3	88.9
Communication	-.23^	.01	68.5	16.8
Family Characteristics				
Income	-.15	-.17	$35,712.8	$22,911.4
Number of Parents in Home	-.44*	-.42*	.85	
Maternal Perceptions of Well-Being				
Parent Stress	.14	.32*	124.6	24.3
Family Support	-.05	.02	31.6	10.6
Family Resources	-.13	-.04	125.5	18.5

perceptions were also predictors of child behavior problems concurrently primarily for externalizing problem behaviors.

The incidence of problem behaviors, especially externalizing behaviors, for this sample is somewhat greater than would be expected. These findings are similar to those of earlier studies of very low birthweight children (e.g., McCormick, Gortmaker, & Sobol, 1990; Minde et al., 1989). Therefore, children who experience low birthweight and severe neonatal medical complications appear to be at risk for

Table 5.25

Internalizing Problem Behaviors Regressed on Child Characteristics, Family Demographics, and Perceptions of Family Well-Being, standard Coefficients (betas)

	Model 1 Child Characteristics		Model 2 Family Demographics		Model 3 Perceptions of Family Well-Being	
Variable	Longitudinal	Cross-Sectional	Longitudinal	Cross-Sectional	Longitudinal	Cross-Sectional
Gender	-.05	-.13				
Temperament	---^	.42*				
Activity	.32*	---^				
Development	-.41*	-.14				
Mother's Age				-.01		
Mother's Education			-.21	.10		
Family Income			.04	.12		
# Parents in the Home			-.19	-.54		
Parent Stress					-.11	.26
Social Support					.05	-.11
Family Resources					-.31	.07
Adjusted R^2	.19*	.25*	.07	.25*	.07	.06

* $p \leq .05$

^ Not entered into regression due to low correlation

Table 5.26

Externalizing Problem Behaviors Regressed on Child Characteristics, Family Demographics, and Perceptions of Family Well-Being, standard Coefficients (betas)

	Model 1 Child Characteristics		Model 2 Family Demographics		Model 3 Perceptions of Family Well-Being	
Variable	Longitudinal	Cross-Sectional	Longitudinal	Cross-Sectional	Longitudinal	Cross-Sectional
Gender	-.19	-.24				
Temperament	----^	.49*				
Activity	.35*	----^				
Development	-.25	.08				
Mother's Age			-.14	-.19		
Mother's Education			-.13	.12		
Family Income			-.08	.09		
# Parents in the Home			----^	-.47*		
Parent Stress					-.14	.60*
Social Support					.03	-.01
Family Resources					-.21	.36*
Adjusted R^2	.18*	.29*	.07	.25*	.04	.22*

* $p \leq .05$

^ Not entered into regression due to low correlation later behavior problems. Yet, birthweight, gestational age, medical severity, and length of stay in the NICU were not related to internalizing or externalizing behaviors.

Both the correlational and regression analyses indicated that among the variables investigated in this study, infant activity level and the child's current temperament were the best predictors of child behavior problems. Level of development was associated with internalizing but not externalizing behaviors. Alternately, family characteristics and perceptions of well-being were more associated with externalizing behaviors than with internalizing behaviors.

In interpreting the findings of this study, it is necessary to remember that many of the measures were completed by the parents. It is possible that child behavior problems and temperament measures may be confounded as others have suggested (e.g., Brody, Stoneman, & Burke, 1988; Lancaster, Prior, & Adler, 1989).

Conclusions

This study addressed the age-at-start intervention question by comparing two randomly assigned groups of medically fragile infants who experienced neonatal intraventricular hemorrhaging. This longitudinal research design was methodologically sound with random assignment to treatment, implementation of treatment verification measures, use of pre- and post measurement, "blind" assessment by certified testers, and multiple measures of child and family functioning. Intervention began for one group (the early intervention group) when the children were 3 months of age (CCA), and for the other group (the delayed intervention group) when the children were 18 months of age (CCA).

The early intervention group received sensory motor intervention from a physical therapist until they were 18 months old. At 18 months of age children in both groups received home-based developmental intervention, with those who needed additional physical therapy receiving it. The determination of frequency of visits was individually determined based on the particular needs of each child and family, but a minimum of monthly visits was advised at least until the children reached the age of 30 months.

Recruitment of children into the sample took place between 1985 and 1988, as EIRI was notified by the participating hospitals of children who fit the sample requirements. The intervention portion of the study ended on September 1, 1990, but annual assessments have continued. The 18-, 30-, 42-, 54-, and 66-month assessments are complete. The 102-month assessments have been started; other children have just completed their 66-, 78-, or 90-month assessment. Therefore, the results of Reassessments #1-#5 are final; those of Reassessments #6 and #7 are preliminary.

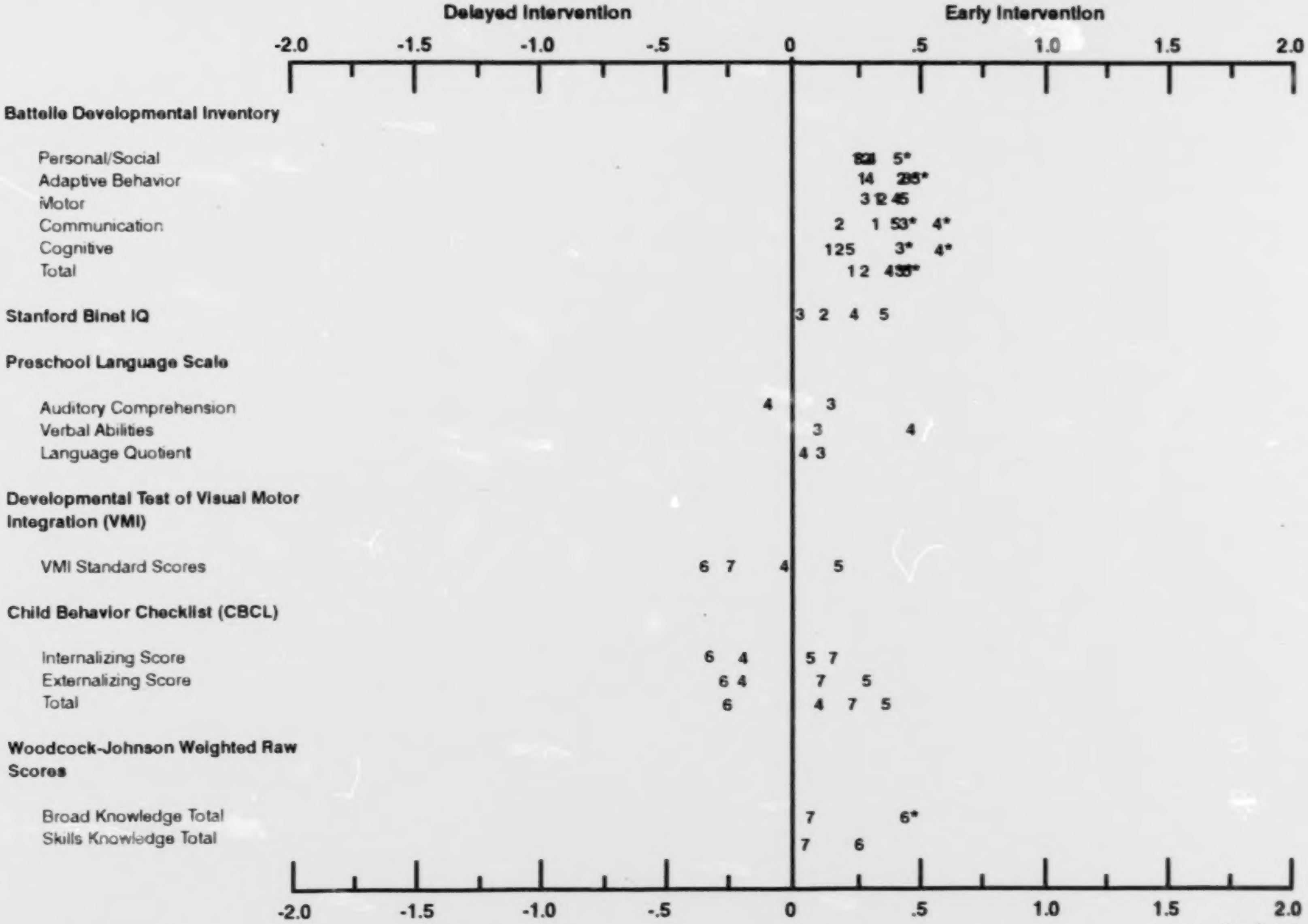
To assist with the integration of the large amount of data collected thus far, the graphical representation shown in Figures 5.3 and 5.4 have been created. The various measures of child and family functioning used in the seven reassessments are listed down the left-hand side. The entries in the center of the figure represent the effect size for each measure at each time it was given (1, 2, 3, 4, 5, 6, or 7 for each respective reassessment). All reassessment scores are based on covariance adjusted means. Entries on the left side of the centerline indicate that the subjects in the delayed intervention group did better, and entries on the right side of the line indicate the early intervention group did better. Those that are statistically significant ($\underline{p} \leq .10$) are circled. Most of the findings are on the right side and favor the early intervention group. After Reassessments 1 and 2, some of the differences between the groups were statistically significant, and the effect sizes of these comparisons indicate approximately one-half of a standard deviation of difference.

In viewing these results, it seems appropriate to address the question asked at the beginning of this report: "Is early intervention for infants who are medically fragile more effective if it starts earlier?" As the children have become older, there does appear to be a slight advantage for the earlier group with respect to child outcomes. For example, the differences between groups on the BDI scores were greater after the first and second reassessments. Three considerations should be noted in evaluating these findings.

First, and most notable, is the fact that the observed effect did not emerge until the children reached 42 months of age. Similar results have been reported by Rauh and associates (Achenbach, Phares, Howell, Rauh, & Nurcomb, 1990; Rauh, Achenbach, Nurcombe, Howell, & Teti, 1988) and the Infant Health and Development Program (IHDP; 1990); both found that statistically significant differences between groups of low birthweight infants who received differing intensities of intervention did not appear until a later age. However, in a replicative study, the South Carolina Medically Fragile Age-at-Start Study reported in this annual report with a similar sample of low birthweight infants who had experienced IVH developmental benefits were not found for those in the early intervention group. Instead, at reassessment #4 (54 month) and #5 (66 month) the delayed intervention group scored statistically significantly higher on the motor domain of the Battelle and the Stanford Binet than the early intervention group.

In a study using the Salt Lake City and the South Carolina samples predictors of developmental outcomes were investigated. The outcome variables were Battelle change scores from Reassessment #1 to #3 and #1 to #4 and Stanford-Binet scores at Reassessment #3 and #4. Neither intervention group assignment nor initial medical characteristics were significant predictors of developmental outcomes. Maternal education and income were the strongest predictors. More research is needed investigating the relationship and interaction between initial medical characteristics, intervention, and the family demographics.

Second, it is important to note that the differences between the groups never reached more than approximately one-half of a standard deviation. This indicates



(continued)

Figure 5.3: Effect Sizes for Child Outcomes for Salt Lake City Medically Fragile Study

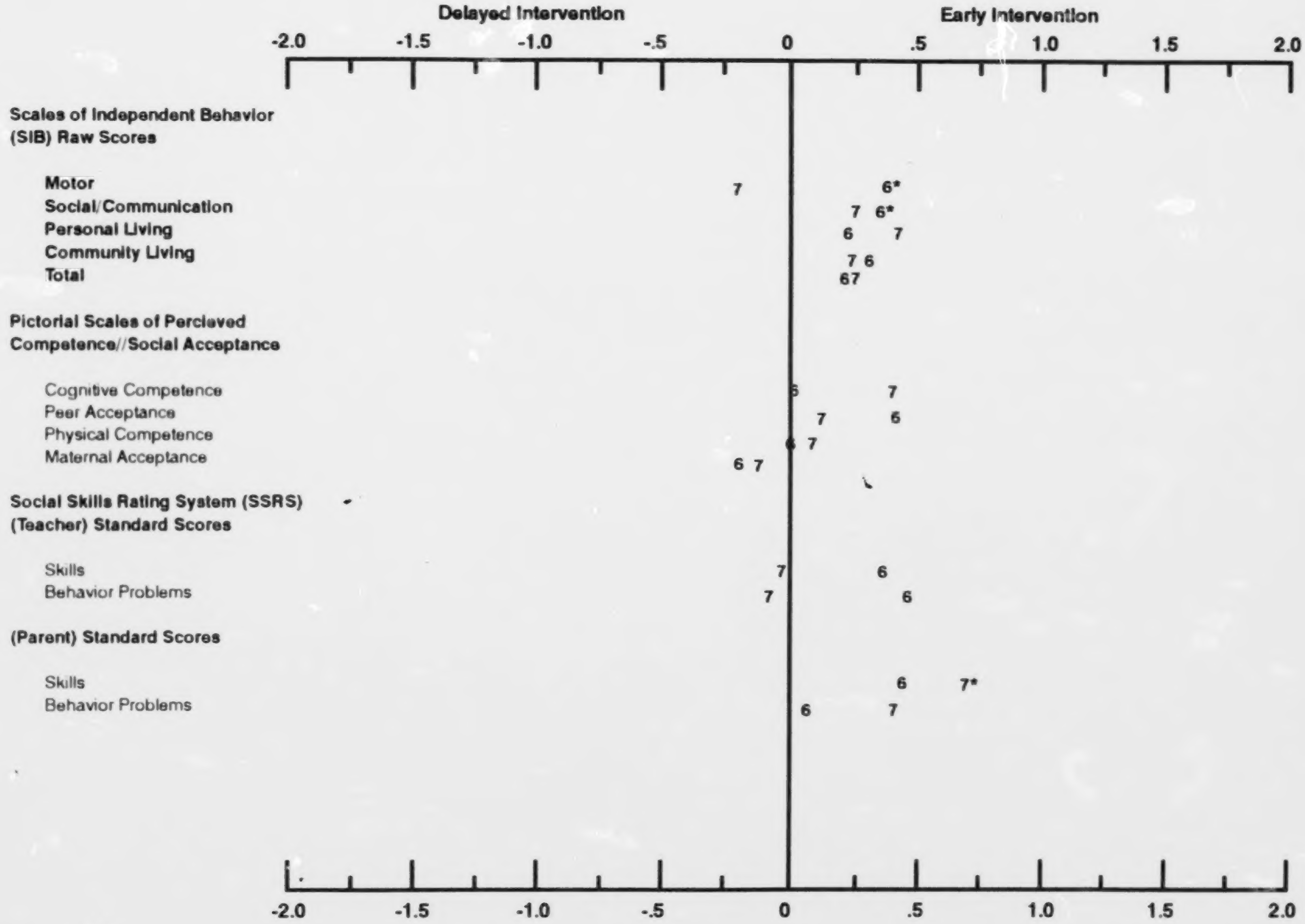


Figure 5.3 (continued)

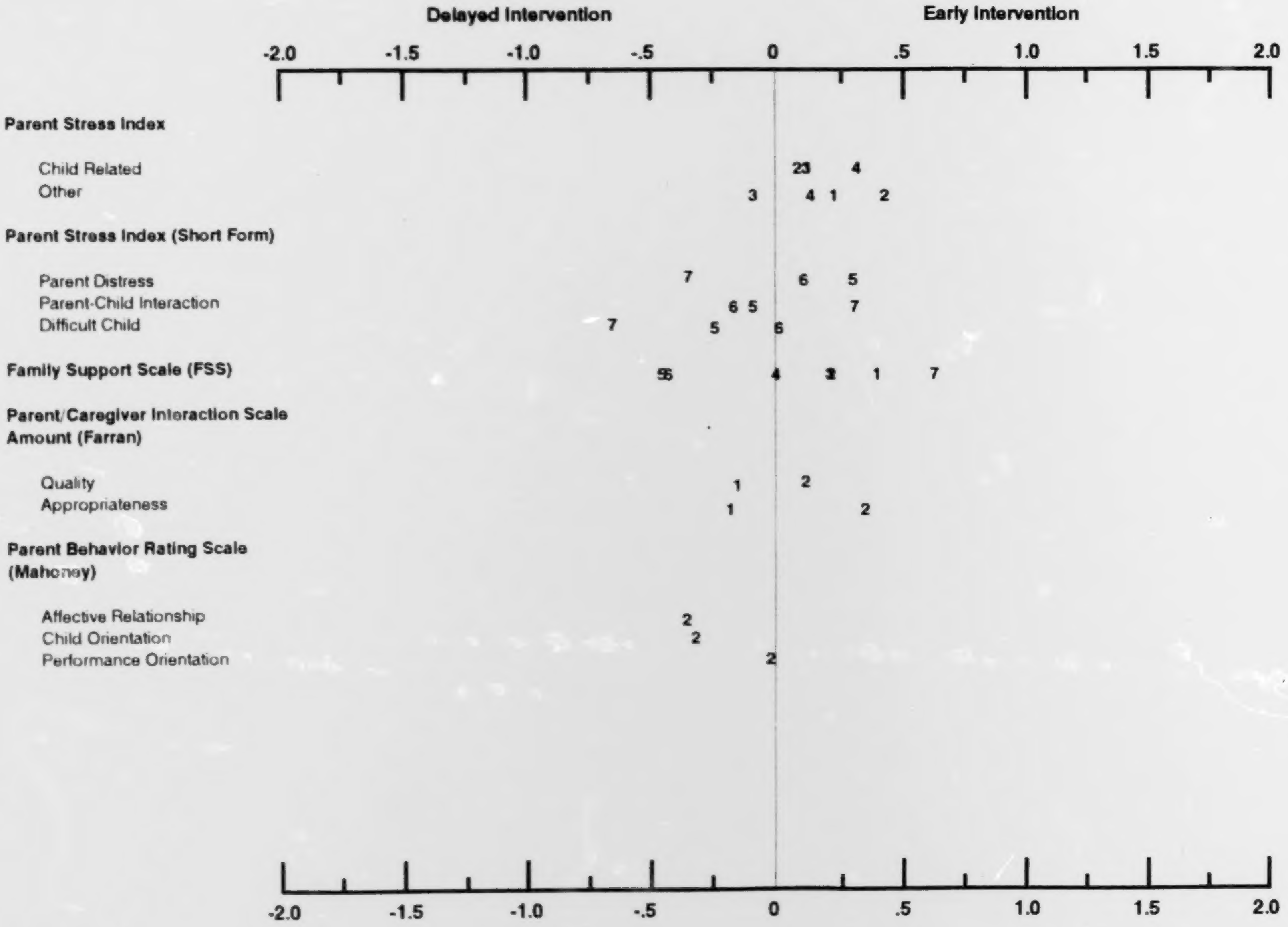


Figure 5.4: Effect Sizes for Family Outcomes for the Salt Lake Medically Fragile Study

that initiating intervention 15 months earlier resulted in only small to moderate gains for the children involved.

Third, it is important to note that corresponding differences were not found on other measures of development (e.g., Preschool Language Scale [PLS], Stanford-Binet). This raises questions about the breadth and robustness of the findings. It will be important to see, as Reassessments #6 and #7 testing are completed, whether the group differences continue.

Regarding family functioning, we hypothesized that the intervention might influence measures of parent/child interaction, or perceptions of stress and/or social support because the intervener modeled behaviors with the child, discussed parent concerns, and asked the parents to complete weekly assignments related to their child's development. Other researchers have found increases in quality of parent/child interactions after initiating similar programs (Resnick et al., 1988) and increases in perceptions of social support after parent involvement interventions (Boyce, 1992b). Differences in these measures were primarily expected at the 18-month assessment, when only the infants and mothers in the "earlier" group were involved in the treatment. Differences between the groups on these measures were not likely at the later assessments because at that time the two groups were receiving the same treatment. However, the expected differences at the first assessment in parent/child interactions, perceptions of social support, or parenting stress were not found, and there is no evidence from this study that starting the intervention earlier had an effect on family functioning outcomes.

It is possible that an even more intense "earlier" intervention program would have resulted in greater differences between the "earlier" and "later" groups at the later reassessments. However, it is important to note that monthly visits by the physical therapist or home visitor, as provided in this study, is among the most frequent service delivery patterns for children who are medically at risk (Roberts & Wasik, 1990). Initiating intervention earlier in life may show greater benefits than initiating it later if the intervention is more intensive, as other researchers (e.g., Piper, et al., 1986) have suggested. Indirect support of this hypothesis is found in Ramey et al. (1992), who reported that children who participated most often in a very intensive intervention program (IHDP) had increased IQ scores and decreased behavior problem scores compared to a group who participated less often in the intervention. However, conclusions about this possibility should be reserved until carefully controlled studies have been done.

In evaluating the importance of beginning intervention early, the costs of the alternative interventions need to be considered as well as the cost benefits of later school placement. Originally, the intervention for the early intervention group cost more than for the delayed intervention group, but the cost was moderate. For that cost, some moderate benefits on child functioning were demonstrated, but no family benefits were found. Presently, it appears from the school placement data that it is costing less to educate the children in the early intervention group than the children in the delayed intervention group. If these findings continue with subsequent school years, they will provide a strong argument in favor of earlier intervention for children with similar risks.

Aside from the intervention information available from this study, this data set provides important information concerning the development of infants who have suffered major neonatal complications. Although all subjects experienced neonatal intraventricular hemorrhaging, a great diversity is seen within the sample on other birth characteristics and risk factors. The study is providing evidence concerning which neonatal factors predict later child functioning. Thus far, days spent in intensive care (NICU), the rating of the severity of sensory impairment, and the rating of the severity of neurological damage are better predictors than birthweight, gestational age, or grade of IVH with this sample.

Development varies greatly within the sample. Many of the children are developing normally, or near normally, but some are experiencing severe delays.

Approximately one-fifth of the sample consistently score below 70 or about two standard deviations below the mean. As the children continue to be followed, more will be learned about the development and school performance of medically fragile children.

In summary, the age-at-start question remains a key issue in the field of early intervention. While interveners may continue to prescribe intervention "as early as possible," the research evidence thus far is limited. In this study, we have limited evidence that earlier might be better, but the effects are small and not consistent across measures where they would be expected. Although the positive finding of a "delayed effect" for the group who received the earlier intervention is tantalizing, much additional work remains before we can be confident about this finding. The final data collection for this sample, and independent replication studies, perhaps using even more intensive "earlier" interventions, are essential for us to understand this important issue. Until more data are available, it would probably be wise to be cautious about promising that medically fragile infants who begin intervention earlier will have a substantial advantage over those who begin intervention later.

CHARLESTON, SOUTH CAROLINA MEDICALLY FRAGILE "AGE-AT-START" STUDY

Project #6

COMPARISON: Infants with Grades I, II, III, and IV Intraventricular Hemorrhage (IVH)--Services begun at 3 months adjusted age versus services at 12 months.

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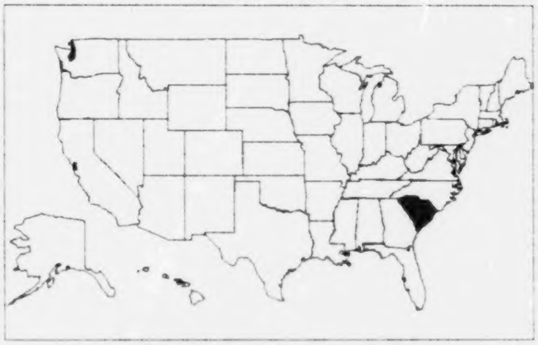
EIRI COORDINATOR: Conway Saylor, Ph.D.

LOCATION: Charleston, South Carolina

DATE OF REPORT: 10-1-94

Rationale for the Study



One of the primary contributors to infant mortality is low birthweight (LBW). In the USA, 6.8% of all newborn babies are LBW (weighing 2500 g or less at birth), and about 1.2% are very-low birthweight (VLBW) (weighing 1500 g or less at birth). This amounts to approximately 225,000 low-birthweight infants per year (National Center for Health Statistics, 1989).

Forty percent of low birthweight infants (or approximately 90,000 infants per year) suffer periventricular-intraventricular hemorrhages (PVH-IVH) within 72 hours of birth. These hemorrhages produce abnormal bleeding from cranial capillaries and result in different degrees of neurological damage based upon the severity of the hemorrhage (Volpe, 1981). Brain-imaging procedures such as real-time ultrasonography and computed tomography (CT) scanning are used to make a positive identification of IVH and to classify the hemorrhage into one of four grades of severity, with Grade I IVH the most mild form of hemorrhage, and Grade IV the most severe (Papile et al., 1978). Dramatic clinical symptoms such as seizures, loss of muscle tonus, cessation of breathing, and unreactive pupils, may mark the onset of IVH; however, at times IVH is clinically silent (Tarby & Volpe, 1982). The importance of PVH-IVH as a major health problem is underscored by the following statistics (Volpe, 1987):

For each 1,000 LBW infants born--

- 400 suffer PVH-IVH
- 100 of the 400 (25%) die immediately
- 85 of the remaining 300 (28%) suffer major neuropsychological impairment

Information as to the future developmental progress of PVH-IVH survivors is somewhat limited and controversial (Hynd et al., 1984). Williamson et al. (1982) found that 29% of Grade I and II IVH LBW infants exhibited moderate disabilities by the age of 3, whereas Papile et al. (1983) found that only 15% of such children could be diagnosed as having these disabilities. Both Papile et al. (1983) and Williamson et al. (1982) found that up to 80% of premature LBW survivors who experienced Grade III or IV IVH demonstrated moderate to severe disabilities, such as cerebral palsy, by the third year of life. Sostek et al. (1987) concluded that the severity of IVH did not predict the infant's developmental progress at 2 years of age; however 40% of the infants in that study showed significant delays at 2 years. But, Bozynski et al. (1984) indicated that these infants are at especially high risk for later motor problems. In spite of compelling data that these infants are at high risk, and increasing in number, there are too few longitudinal studies which carefully document the behavioral developmental course of these infants, much less the impact of intervention on that course (Vohr & Garcia-Coll, 1988). This study represents a significant expansion over previous studies of the low birthweight infants with IVH in that it involves longitudinal follow up of a relatively large group of VLBW infants after random assignment to either early or delayed intervention. The details of this study will follow after brief mention of some of the pertinent literature.

Review of Selected Literature

Although there is a fair amount of research on interventions for premature low-birthweight babies (see Bennett, 1987; Casto et al., 1987; Cornell & Gottfried, 1976; Klaus & Kennell, 1982; Masi, 1979; Ramey et al., 1984; Sandall, 1990; for reviews), most have focused on in-hospital stimulation or parent training as opposed to a comprehensive intervention; and virtually all have excluded children who have suffered major neurological insults such as IVH. Exceptions include studies by Resnick et al.,(1987-88), and Piper et al., (1986), who included neurologically impaired infants.

Three recent studies examined the effectiveness of early sensory motor therapy for infants at-risk for developmental delays. Goodman et al. (1985) divided infants into high and low risk for motor problems based on an early assessment, and alternately assigned them to control and intervention groups. A program of weekly home visits began for the intervention group at three months of age. The results of this study indicated that the intervention group did not benefit from the intensive intervention. One methodological flaw with this study that was not clearly discussed in the report was the fact that infants in the control group who started to develop motor problems were removed from the control group and given intervention. This protocol might have resulted in those infants who could have demonstrated the efficacy of the intervention being removed from the analyses.

Piper et al. (1986) randomly assigned 134 NICU graduates weighing $\leq$ 1500 and/or having serious medical factors (birth asphyxia, seizures, CNS dysfunction with abnormal EEG tracings) to one of two groups. The control group had routine follow-up and referral through their neonatal follow-up programs. The experimental group received this routine follow-up as well as physical therapy intervention on a weekly basis for first three months and a biweekly basis for the next nine months. There were no significant differences between groups on any of the neuro-developmental measures administered at 12 months. Regardless of treatment condition, the ELBW subjects (≤ 750 g) exhibited more problems across measures compared to their "heavier" counterparts.

Palmer et al. (1988) randomly assigned 48 infants with mild and severe spastic diplegia to groups receiving either 12 months of physical therapy or 6 months of infant stimulation followed by 6 months of physical therapy. After 6 months of therapy, the infants in the physical therapy group had significantly lower scores on Bayley mental and motor scales and were less likely to walk. These differences persisted after 12 months of therapy. In addition, there were no significant differences in the number of infants with contractures or needing bracing, and the physical therapy group had lower mental development scores. The major difference between this study and the current study is the enrollment of children who already show motor problems, rather than those at risk for development of these problems.

Two highly intensive intervention programs produced somewhat conflicting results. Resnick et al., (1987) evaluated the effects of a multidisciplinary infant development program on low birthweight infants at 12 and 24 months of age and found significant differences favoring the experimental group on both physical and mental indices. The Infant Health and Development Program (IHDP, 1990, found similar differences at 36 months for all infants except those with IQ scores lower than 70. These infants failed to demonstrate any intervention effects. As discussed later, the differences in populations and intervention packages were so marked, it is hard to directly compare the present study and the IHDP. In sum, further research in this area is clearly indicated.

Overview of Study

Other than the study by Boyce and her colleagues in this Institute (Boyce, Smith, Immel, Casto, & Escobar, 1993), there are no studies to date which examine parameters such as age-of-start in a controlled fashion with this population. There has been literature describing components of "state of the art" intervention for families of infants with handicapping conditions (e.g., McDonnell & Hardpan, 1988), and this intervention incorporated most of the recommended components (for review see Saylor, Levkoff, & Eklsnin, 1989). However, there is clearly a need to put our "best practice" techniques to the test in controlled, longitudinal studies such as the one that follows. As noted earlier, intervention programs for low-birthweight infants have generally focused on in-hospital stimulation or parent training intervention, and most have excluded children who have suffered major neurological insults such as IVH (for reviews see Bennett, 1987; Casto et al., 1987; Cornell & Gottfried, 1976; Klaus & Kennell, 1982; Masi, 1979; Ramey et al., 1984). At issue for this study are the effects and related costs of beginning intervention at different ages for infants who have serious medical problems and who routinely spend up to three months in intensive care units.

The specific comparison for this study was between infants receiving intensive motor-development oriented intervention beginning at 3 months corrected age and infants who began receiving comprehensive developmental services at 12 months of age. This comparison was chosen because a high proportion of the developmental problems encountered by these infants are motor development related. Since these infants routinely receive only medical follow-up until a particular problem or delay is noted, this study provided a good opportunity to test the age-at-start hypothesis.

Methods

This study was implemented in collaboration with the Departments of Pediatrics and Psychiatry of the Medical University of South Carolina in Charleston, South Carolina. The full-time staff of this intervention project consisted of a home interventionist and two physical therapists. The project was overseen on a part-time basis by a director and supported on a part-time basis by a diagnostician, a secretary, and a Post Doctoral Fellow who served as coordinator.

Subjects

The sample was composed of 66 infants recruited from both urban and rural areas around Charleston. Subject recruitment began in October, 1986 and was closed in October, 1988. Of 66 originally recruited, 64 infants have received a pretest and a 12 month re-assessment, 58 infants have had their 24 month re-assessment, 57 infants their 36 month re-assessment, 37 their 54 month re-assessment, 49 their 66 month re-assessment , 37 their 78 month re-assessment (to date), 22 their 90 month reassessment (to date), and 5 their 102 month reassessment.

Recruitment and random assignment. Infants qualified for participation in the research if they had been patients in the NICU at the Medical University of South Carolina, if they had experienced intraventricular hemorrhage (IVH) or had a birthweight of less than 1000 g, and if they resided in the catchment area for treatment (60-mile radius). For purposes of assignment, severity of IVH was divided into mild (Grades I and II IVH) and severe (Grades III and IV IVH) categories.

Parents of eligible infants were contacted while the infant was still in the NICU, and subsequent telephone contact was made shortly after discharge. For each infant who met the study criteria, parents were required to indicate willingness to participate in either the experimental or the control conditions, depending upon where they were placed by random assignment. Infants with IVH were randomly assigned to treatment (Early) or control (Delayed) conditions by a roll of a four-sided die after stratification by severity of IVH (mild, Grade I or II, or severe Grade III or IV) and birthweight (under 1000 g or over 1000 g). Those infants who had birthweights under 1000 g, but did not have IVH, were randomly assigned to treatment or control in a 5th cell.

The only people who knew the actual order of eligibility and enrollment of subjects were the site director and the research coordinator. The dates on which infants were born were the basis for sequence of enrollment, and infants were assigned to experimental conditions in order of eligibility.

Attrition. A total of 66 subjects were originally enrolled and pretested in this project. Two subjects withdrew their consent to participate immediately after being pre-tested and were thus never meaningful participants in the study. The remaining 64 of the infants enrolled were still in the program for the first reassessment, 58 were seen for the second reassessment, and 57 for the third reassessment. Of the 9 who were not available by 36 month reassessment, two dropped out immediately as described above, three died, two were lost when foster placement was repeatedly re-assigned, three relocated without giving the project notice or address information and/or declined to participate. Thus, the present findings are based on 97% of the originally enrolled subjects at reassessment one, 88% at reassessment two, and 86% at reassessment three. A series of t-tests showed no significant differences on medical or demographic variables for the 53 subjects completing 36 months and the 9 lost to follow up.

Due to a lapse in funding, only 37 subjects, or 56% were invited in for the 54 month reassessment. The majority of these subjects (49 or 79%) were recontacted for the 66 months assessment, and remain active in subsequent evaluations to date.

Medical and demographic characteristics. Table 6.1 summarizes the available demographic data for the 64 infants who represented the initial study participants. All of the children were from families who resided within sixty miles of Medical University of South Carolina in Charleston, South Carolina. This included populations from isolated rural areas, small towns, suburban areas, and the Charleston Metropolitan area. The ethnic background of the sample was approximately 65% Black and 35% Caucasian. All of the participants lived in homes where English was the primary language, and there were slightly more two parent than single parent families (57% vs 43%). Forty-one percent of the enrolled families were receiving public assistance. Only one variable differed significantly between the early and

Table 6.1

South Carolina Medically Fragile Study: Comparability of Demographic Characteristics for Subjects in Delayed vs Early Groups

	Subjects in 12 month reassessment Analyses							
	Delayed Intervention			Early Intervention				
Variable	$\bar{X}$	(SD)	N	$\bar{X}$	(SD)	N	p Value	ES
▮ Age of mother in years	29.3	(7.4)	30	28.0	(6.1)	34	.45	-.18
▮ Age of father in years	30.8	(6.7)	28	31.1	(6.5)	31	.87	.04
▮ Percent male'	30%		30	68%		34	.00	.75
▮ Years of education for .30 mother	12.9	(2.0)	26	12.3	(2.1)	34	.27	-
▮ Years of education for -.15 father	12.7	(2.0)	23	12.4	(1.9)	31	.63	
▮ Percent with both parents' living at home	55%		29	59%		34	.77	.07
▮ Percent of children who' are Caucasian	33%		30	38%		34	.71	.09
▮ Hours per week mother employed	17.8	(19.5)	17	14.3	(18.3)	23	.57	.18
▮ Hours per week father employed	39.9	(13.4)	18	41.0	(17.7)	20	.84	.08
▮ Percent of mothers' employed as technical managerial of above	11%		27	6%		34	.50	-.17
▮ Percent of fathers' employed as technical managerial of above	16%		25	4%		27	.19	-.35
▮ Total household income	$18,125	($19,650)	28	$14,662	($11,886)	34	.42	-.18
▮ Percent receiving public' assistance	41%		27	39%		33	.91	-.03
▮ Percent with mother as' primary caregiver	89%		28	94%		34	.53	.16
▮ Percent of children in' daycare more than 5 hours per week	40%		30	24%		34	.17	.33
▮ Number of siblings	1.1	(1.6)	28	1.1	(1.3)	34	.89	.00
▮ Percent with English' as primary language	100		29	100		34		

delayed intervention groups. There was a higher proportion of males in the early intervention group than in the delayed intervention group (68% versus 30%, respectively).

Table 6.2 displays the comparisons for medical data of the early versus delayed intervention groups. In spite of stratification by birthweight and grade of bleed, clinically significant differences favoring the "delayed" intervention group were found. Specifically, the early intervention group had a lower gestational age and a higher percent of the group had Retinopothy of Prematurity (ROP- visual problems common in premature birth). Although the differences were not statistically significant, the effect size magnitude called our attention to other potentially important medical variable group differences. Specifically, it was noted that the early intervention group had a higher number of days on ventilation and a higher percent of cases with Respiratory Distress Syndrome. Because of their clinical importance and potential relationship to developmental outcomes, these variables, along with birthweight, seizures, IVH grade, and length of hospital stay, were incorporated into a Medical Severity Index (Figure 1) which was used as a covariate for subsequent group comparisons.

MEDICAL SEVERITY INDEX

SC MEDICALLY FRAGILE SITE

Score One if:

____1. GA less than or equal to 30
____2. Days on Ventilator greater than or equal to 10
____3. Child had BPD and RDS
____4. IVH grade greater than or equal to II
____5. Child had ROP
____6. Birthweight less than 1500
____7. Child had seizures

Figure 6.1: Medical Status Index

Table 6.2

South Carolina Medically Fragile Study: Comparability of Groups on Medical Characteristics

	Subjects in 12 month reassessment Analyses							
	Delayed Intervention			Early Intervention				
Variable	X̄	(SD)	N	X̄	(SD)	N	p Value	ES^
§ Birthweight (g)	1231	(518)	30	1107	(357)	34	.27	-.24
§ Grade of IVH (% with Grade III or IV)	48		30	62		34	.27	-.27
§ Gestational Age (Weeks)	30.3	(3.2)	30	28.9	(2.6)	34	.08	-.44
§ Days on Ventilator	14.8	(23.7)	30	20.4	(23.4)	34	.34	.24
§ Apnea (%)*	43%		30	56%		34	.34	.23
§ Seizures (%)*	7%		30	15%		34	.39	.21
§ Respiratory Distress Syndrome (%)*	63%		30	79%		34	.17	-.34
§ Bronchopulmonary Dysplasia (%)*	36%		30	41%		34	.73	-.08
§ Retinopathy of Prematurity (%)*	30%		30	59%		34	.02	-.56

^ Effect Size (ES) is defined here as the difference between the groups (Early minus Delayed) on the x scores, divided by the standard deviation of the Delayed Intervention Group (see Cohen, 1977; Glass, 1976; Tallmadge, 1977 for a more general discussion of the concept of Effect Size).

* Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scored as "0."

Alternative Intervention Programs

The comparison for this study was of an early versus delayed intervention program. Intervention occurred in two phases. During Phase I, the subjects assigned to the Early Intervention group received a sensorimotor intervention beginning when the infants were 3 months of age, and the Delayed Intervention group received the routine medical follow-up services available to the community in general. In Phase II, which began for all subjects at 12 months of age, all infants received home intervention services and sensorimotor services as needed.

Before the implementation of this project, all infants who were in Neonatal Intensive Care Units were referred to the South Carolina State Department of Health

Neonatal Follow-up Clinic and received routine medical follow-up from private physicians or clinics. Previous funding for these services was provided by the South Carolina Department of Health; or by patient self-pay, for those using private physicians or clinics. These services remained the standard level of care for all infants in the treatment area during the period described in this report. Infants who were assigned to the control group for this project typically received no other services during the first phase of the study, as very few services were available. However, parents were able to access services in the community if they desired. Parents were queried about services they had accessed during the time period of the study, and these results are described later.

During both the early and delayed phases of the intervention project, the types of intervention services received were based on the Curriculum and Monitoring System (CAMS) (Casto, 1979). The Curriculum and Monitoring Systems (CAMS) is an early intervention curriculum system designed to meet the educational needs of young children with disabilities served by the Multi-Agency Project for Preschoolers (MAPPS). The project collected data attesting to the efficacy of the program and was validated as an exemplary program for national dissemination by the Joint Dissemination Review Panel (JDRP) of the U. S. Department of Education. It was revalidated in 1985 and 1992. MAPPS is one of only 21 early intervention projects validated by the JDRP. MAPPS is also a National Diffusion Network (NDN) program and has replication sites nationwide.

Each of the curriculum programs is printed in an easy-to-use block style design and bound in a notebook. This format was selected to allow persons administering the program to photocopy individual pages for use by the parents or trainers working directly with the children. With training, CAMS can be used by parents, teachers, and paraprofessionals in the home or an institutional/school setting.

The CAMS is designed to stimulate optimal development by programs in five areas: (a) receptive language, (b) expressive language, (c) motor development, (d) self-help skills, and (e) social-emotional development. The motor domain was the primary domain addressed during the early intervention. Beginning at 12 months, both delayed and early intervention subjects received intervention in all five domains.

The **Receptive Language Program** teaches the student skills that do not require the child to talk but are necessary in the understanding of oral language. Skills include identifying objects, following commands, and touching body parts.

The **Expressive Language Program** teaches children general speaking skills, beginning with the formation of sounds and proceeding through the development of simple grammatical sentences. It focuses on language-building articulation.

The **Motor Program** is designed to teach gross and fine motor skills. The program stimulates normal motor development, beginning with raising the head and proceeding through running, hopping, and drawing shapes. This program is intended for children with mild to moderate impairments.

The **Self-Help Program** is designed to teach basic skills for self care. Included in the curriculum are feeding, dressing, personal hygiene, and toileting skills.

The **Social-Emotional Program** is designed to teach basic social-emotional skills to both normal and developmentally delayed children. The program, which is sequenced developmentally, begins with teaching a child to respond to a person and proceeds through teaching him to handle frustration and exhibit self-control.

Early Intervention Program - 3 to 12 Months

Between 3 and 12 months corrected age, subjects in the early intervention group were scheduled for twice-monthly one-hour sessions with the physical therapist. The therapist worked with the infant and parents using the Motor Program of the CAMS (Casto, 1979). First, a placement test was administered in the motor skills domain to determine which objectives should be offered to the child. Second, curriculum books were provided with developmentally sequenced objectives and activities for assisting in a child's gross and fine motor development for ages birth to 5 years of age. Each child's program was individualized.

A typical intervention session was conducted by a therapist who worked with the child, with the parent present. The physical therapist also instructed the parent on activities that the child could do at home, and the parent practiced and demonstrated competence on these activities before beginning home intervention. The parents were requested to work with the child at home for at least 20 minutes per day, 5 days per week, on techniques they learned in the intervention sessions. The physical therapist telephoned the parent on weeks they did not meet to answer questions and provide guidance on implementation of intervention techniques. Attendance and progress were monitored on an ongoing basis by the physical therapist's progress notes, and the motor program placement test checklist were updated as goals were met.

Intervention Program - 12 months to Transition

At 12 months corrected age, all subjects in the early and delayed intervention groups began expanded intervention programs utilizing all five domains of the CAMS programs. A child development specialist administered the CAMS placement tests, determined developmental levels, and worked with parents to set appropriate goals for intervention in each domain. All subjects were given placement tests in motor, social-emotional, self-help, receptive language, and expressive language domains and then participated in an expanded intervention program, which included weekly contacts with an infant specialist. The interventionist alternated twice monthly home visits with telephone contacts and encouraged parents to attend monthly center based sessions for parent-child dyads and siblings.

A child development specialist was scheduled to meet with parent and child for one hour every other week to provide intervention. For each session, an objective was determined for the child, the child development specialist modeled the training for the parent, and the parent demonstrated the technique. The parent was asked to spend 20 minutes each day, 5 days each week providing similar intervention with their child at home. The child development specialist called the parent via telephone weekly between home visits to check on progress and answer questions. When the child was seen for the next session, the child development specialist had the parent elicit the new behavior from the child. If the child demonstrated competence in that area, a new objective was chosen and modeled for the parent.

For example, the objective for a child might be to point out facial features. The specialist would teach the parent an exercise to teach the child to identify facial features. At the next meeting, the parent would have the child point out facial features. If the child showed competence in that area, a new objective would be established. Depending on their needs, some children would have objectives in several domains, others in only one. Recommendations were also provided to parents regarding problems or concerns such as toileting, feeding, or misbehavior.

If a child in the delayed intervention group was identified by the placement test as having a motor delay, s/he was referred to a physical therapist for motor intervention through the usual community or MUSC (Medical University of South Carolina)-based programs. Those children in the early intervention group who still required motor services either continued meeting with the physical therapist or was referred as above. If a child who received motor services in the early intervention group no longer required those services, those services were discontinued and only the home intervention was delivered.

In addition to the goals centering on infant developmental progress, individual family goals were set and addressed and eventually were formalized as IFSP's (Individualized Family Service Plans). Especially after the child's second birthday, the IFSP's tended to include goals of qualifying for and seeking funding for appropriate additional services. Children were transitioned out of the program between their second and third birthdays, depending on the availability of needed services and the lag time in the community's assessment and referral processes.

Treatment Verification

White (1987) discussed two important issues in verifying that an early intervention program occurred as it was intended. First, delivery of intervention must be examined to ascertain that the program which is being delivered is the same as that which was described in the methodology of the proposal and reports. Second, the extent to which infants and their parents received and participated in the program must be examined. The SC-IVH project implemented several procedures to verify that the intervention was implemented as intended.

The first treatment verification procedure was a formal site review, conducted annually. The SC-IVH site reviews were conducted on September 20-21, 1987, April 25, 1988, and June 1, 1989. The purpose of the site review was to collect information regarding the nature and quality of the early intervention services delivered at this site. Documentation of treatment implementation occurred to ascertain that the intervention services were provided as intended and that the project remained faithful to the research protocol. The site review was conducted according to procedures described in the Guide for Site Reviews of EIRI Research Sites, in the Treatment Verification Handbook for Research Sites (EIRI, 1987). The site was rated "excellent" on all aspects of the evaluation at all visits, except for implementation of formal Individualized Family Service Plans. Although family issues were being addressed, South Carolina had not formalized its guidelines for the IFSP, and there was no document of this specific title and format on the charts of the oldest participants in the projects. A final site review was conducted in May 1990, to discuss the evaluation and intervention for the infants under the same site review guidelines.

In addition to verifying that the intervention program continued to be implemented as originally intended, three methods were used to examine parental participation in the intervention. First, the interventionists tracked the number of center and home based visits that an infant attended during each month. Second, the interventionists asked the parents once a month to estimate the amount of time during the past week that they spent working with their infant on activities suggested by the interventionists. When the interventionists recorded this information, they also rated the parents' accuracy of estimation. Finally, the interventionists were asked to rate the parents once a year on three aspects of their participation in the intervention program. The interventionists used three point scales (1 = low, 2 = average, and 3 = high) to rate the parents' attendance of scheduled appointments, their knowledge of the information that the intervention was designed to provide, and their support of the goals and methods of the intervention program. Table 6.3 represents the data on the sensory motor intervention (Phase I - ages 3-12 mo) based on these treatment verification methods.

Table 6.3

Parent Participation in the Phase I Sensorimotor Intervention

Variables	x	(SD)	n	Minimum	Maximum
Percent of scheduled visits attended	64		29	17	120
Number of hours per month working with interventionist	1.39	(.5)	29	.3	2.4
Number of Hours per week working with child on suggested activities (Parent Report)	2.2	(.7)	16	1.3	3.5
Interventionists' rating of accuracy of parents' time report	2.3	(.6)	16	1	3
Interventionists' rating of quality of parent participation					
1. Attendance	2.1	(.8)	29	1	3
2. Knowledge	2.2	(.7)	29	1	3
3. Support	2.2	(.8)	29	1	3

Based on percentage of scheduled visits attended x 2 hours per visit.
1 = low, 2 = Average, 3 = high

Additional treatment verification was undertaken during 1990-1991 to verify participation in intervention after 12 months (Phase II-all participants). A structured interview soliciting both quantitative and qualitative data about treatment participation was administered by a Post-doctoral level, skilled clinical researcher to 47 of the 58 families, still active in the study. In addition to soliciting retrospective data about level of participation in this program and reasons for transition/termination, the interviewer collected data about concurrent therapies and services accessed by the families, and received releases of information to verify and elaborate on information provided by parents. Subanalyses reported in later sections compare high participation and low participation families on these dimensions.

Cost of Alternative Interventions

The cost of delayed versus early intervention was determined using the "ingredients" approach described by Levin (1983). The figures in Table 6.4 are based on actual expenses for each, including personnel, space, equipment, supplies and volunteer time. The cost per child for the Early Intervention group represents the accumulated costs of intervention from October 1986 to October 1988. For Early Intervention participants the total program cost included two years (from 3 months adjusted age to twenty seven months adjusted age) and two phases of intervention as outlined under the intervention program description. The cost per child for the Delayed Intervention group represents the cost for services from the date these children turned 12 months of age and services began until October 1988, the end of FY 1987-88. In Table 6.4, cost per child estimates in Years 1 and 2 are adjusted for inflation so that all figures are comparable in 1990 constant dollars.

Table 6.4

Cost Per Child for South Carolina IVH Site (1990 Dollars)

Resources	Early Intervention	Delayed Intervention
Agency Resources		
Direct Service Personnel	$3,140	$1,220
Administration		
Program	1,660	771
University	1,435	639
Occupancy	307	101
Equipment	56	17
Transportation	600	443
Materials/Supplies	146	74
Telephone	71	36
Subtotal	**$7,415**	**$3,301**
Contributed Resources		
Parent Time	2,500	1,221
Others	16	
Subtotal	**$2,516**	**$1,221**
TOTAL *	***$9,931***	***$4,522***

* Totals may not add up due to rounding errors.

To arrive at the cost per child, total program costs were determined for each group and divided by the number of children in the group: in Year 1, the total number of children receiving intervention was 24; in Year 2, 38 children (both early and delayed intervention) were receiving services. As illustrated in Table 6.4, program costs included direct service and program and university administration, occupancy, equipment, transportation, materials and supplies, and telephone used for the respective groups.

Direct service personnel costs included wages and benefits for the physical therapist, and the interventionists. Each of these were pro-rated according to actual time spent on intervention-related activities. Program administrative costs included the pro-rated salaries and benefits for the psychologist, coordinator, interventionist, and secretary according to their time spent on administrative duties for the intervention. Research costs in this, and all other resource categories, naturally, were excluded. The university administrative cost was based on the university indirect rate for general, departmental, and sponsored projects administration (24%). Occupancy charges were calculated based on the University's rate per square foot for office space, utilities, maintenance, and insurance pro-rated according to program usage. Equipment costs included the cost of office furniture and intervention equipment. These costs were based on market replacement values for each item which are annualized at a rate which accounts for interest and depreciation and pro-rated according to program usage to determine the annual equipment cost. Agency transportation cost for home visits were calculated at $.21 per mile based on actual mileage. In addition, the project reimbursed several parents for bringing their child to the center for PT treatments in Year One.

Because the program relied heavily on parent participation for both home visits and conducting intervention with their own child in the home, the opportunity cost of parent time was also included. These costs are presented as "contributed resources" on Table 6.4. Parent time included time spent in (1) center and home visit sessions with either the physical therapist or the interventionist; and (2) intervention activities recommended by the program for each parent and child at home. Parents spent an average of 121.2 hours per year in session with professionals and conducting intervention activities at home. Parent time was assigned the value of $9 per hour based on the average hourly earnings plus benefits for full-time work for women in the U.S.

Thus, for children entering the program at 3 months adjusted age and receiving two years of individualized intervention from both professionals and their professionally trained parents, the undiscounted cost of the program was $9,931 per child, while for children entering the program later at 12 months, the undiscounted cost was $4,522 including the value of parent time. The cost per child for intervention in Year 2 was less than Year 1 because of the greater emphasis on physical therapy in Year 1, which costs more than services from the educationally-trained interventionists who began working with the children in year two.

Data Collection

Data were collected for this study to determine the effects of intervention upon the child and the family. The assessment instruments were chosen to provide some consistency of data collection across sites, but also to provide information about children who experienced intraventricular hemorrhage at birth and the unique experiences of their families. In the subsequent section the measures were collected by a local diagnostician who was unaware of the group membership of children or the specific purposes of the study. Testing was scheduled directly with the diagnostician by the site coordinator. Children were enrolled in this study in two cohorts. The first 18 children were enrolled before the full battery of pretest measures was finalized. Therefore, the pretest for these children consisted only of the Battelle Developmental Inventory (BDI). The next 45 children were enrolled after the full testing battery (described below) had been developed. Forty-five (70%) of the infants who reached the first reassessment received the full assessment battery at pretest.

Recruitment, training, and monitoring of diagnosticians. All testers recruited for the study successfully completed the certification process required for administration of the Battelle Developmental Inventory. The training involved approximately 4 hours of independent study, 8 hours of group training, and a minimum of three practice administrations with 85% interrater agreement required. All of the diagnosticians had a master's degree in Clinical Psychology or an advanced degree and/or certification in Clinical or School Psychology, and had extensive experience assessing children. All the testers were naive to the subject assignment. A doctoral level supervisor with a doctoral degree in school or clinical psychology coordinated the scheduling of the testing, collected the family measures, and ensured the quality of the test results via tester reliability checks and double-checking protocols.

Pretest. At 3 months corrected age (prematurity corrected to 40 weeks plus 3 months), all infants were tested with the Battelle Developmental Inventory (BDI). At the same time the parents completed the Parenting Stress Index (PSI), an assessment of the stress perceived by the parents; the Family Support Scale (FSS), a measure of the number of different sources of support available to families with young children; the Family Resource Scale (FRS), a measure of the different kinds of resources available; the Family Inventory of Life Events and Changes (FILE), which assesses the life events and changes experienced by the family during the previous 12 months; and the Family Adaptability and Cohesion Evaluation Scales (FACES III), an assessment of the cohesiveness and adaptability of the family. All test and questionnaire protocols were sent to the program coordinator for scoring and placement in a data file. Parents were paid $20 for their time in completing the evaluation session. This battery of tests provided information regarding both the infant's developmental level and early family reaction to the newborn.

Reassessment. Reassessments occurred first at 12 months corrected age and annually thereafter for three years. Beginning with the fourth reassessment, evaluations occurred annually on the half year (age 5.5, 6.5 and so on) and were based on chronological rather than adjusted age. The reassessment battery was administered by diagnosticians who were "blind" to the subject's group assignment. The child was given the BDI; the parent completed the PSI, FILE, FACES III, FSS, FRS, a survey of additional services received by the child in the last year, a report of child health during the previous year, and a parent demographic survey. In addition, videotapes were made of mother-infant interaction in a semi-structured play session.

The parent-child interaction videotape involved the parent and child in play activities. In the first section, the mother and child were asked to play together for 15 minutes "as they would at home." Then, for one minute, the parent encouraged the child to put the toys away. For the next two minutes, the parent read to the child. Then the parent was asked to leave the room for 45 seconds, and taping continued for two minutes after the parent returned to the room. Parents were paid a $30 incentive for the testing and videotaping. Tables 6.5 and 6.6 summarize the number of subjects tested with each instrument at each observation period. Table 6.7 summarizes the instruments employed for these assessments.

Table 6.5

Number of Subjects Receiving Each Part of SC-IVH Assessment in First Three Years

Measures	Pretest 3 months AA	First Re-assess 12 months AA	Second Re-assess 24 months AA	Third Re-assess 36 months AA
BDI	66	64	58	57
Binet	n/a	n/a	n/a	57
MCDI*	n/a	50	55	57
PSI	48	64	58	57
FSS	48	64	58	57
FRS	48	64	58	57
FILE	48	64	58	57
FACES	48	64	58	57
Video	48	64	58	57

* For the older subjects, 12 months MCDI's were collected in a separate clinic scheduled two to three months earlier (12 mo CA) and were not considered valid for outcomes in this study. At two and three year data points, missing data on most measures reflects parents' failure to complete the form as requested. Missing video data reflects technical difficulties in recording or coding the tapes.

Table 6.6

Actual (Additional Expected) Number of Subjects Receiving Each Part of SC-IVH Assessment in Years 4-6

Measures	Reassessment #4 54 mo Ca	Reassessment #5 66 mo CA	Reassessment #6 78 mo CA	Reassessment #7 90 mo CA
BDI	37	48(4)	na	na
Binet	32	39(4)	na	na
Woodcock-Johnson	na	na	33(17)	13(32)
SIB	na	na	35(17)	18(32)
PSI or PSI Short Form	36	49(4)	35(17)	18(32)
FSS	36	49(4)	36(17)	18(32)
FRS	33	45(4)	36(17)	18(32)
Video	37	49(4)	36(17)	18(32)
VMI	na	na	32(17)	15(32)
Social Skills Rating Scale	na	na	35(17)	18(32)
Achenbach Child Beh. Checklist	na	38(4)	36(17)	18(32)

Table 6.7

Description of Tests Administered for SC-IVH Study

MEASURES	DESCRIPTION
Battelle Developmental Inventory (BDI) (Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984)	A norm-referenced test of developmental functioning completed through child administration and parent interview. Assesses personal/social, adaptive, motor, communication, and cognitive skills, and provides a total score.
Stanford-Binet Intelligence Test Form L-M (Terman & Merrill, 1973)	The Stanford-Binet is a norm-referenced measure of general intellectual ability.
Minnesota Child Development Inventory (Ireton & Thwig, 1974)	The MCDI is a maternal report paper and pencil measure which provides norm-referenced age-equivalent scores in general development, gross and fine motor, expressive language, comprehension-conceptual, situation comprehension, and self-help skills.
Woodcock-Johnson Test of Achievement--Revised (WJ-R) (Woodcock & Johnson, 1989)	A norm-referenced test of achievement. The test consists of six aspects of scholastic achievement: Letter-Word Identification, Applied Problems, Dictation, Science, Social Studies, and Humanities. Child is the respondent.
The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983)	Assesses a child's perceived competence and social acceptance in four specific domains: Cognitive Competence, Physical Competence, Material Acceptance, and Peer Acceptance. Child is the respondent.
Scales of Independent Behavior (SIB) (Bruininks, Woodcock, Weathermen, & Hill, 1985)	The SIB is a norm-referenced test which assesses the functional independence and adaptive behavior of a child. The test is organized into four subdomains: Motor Skills, Social and Communication Skills, Personal Living Skills, and Community Living Skills, Parent is interviewed for information.
The Child Behavior Checklist (CBCL)	This test is designed to obtain standardized data on children's social competencies and internalizing and externalizing behavioral problems as reported by their parents.
Social Skills Rating System Parent Form (PSSRS) Teacher Form (TSSRS) (Gresham & Elliot, 1990)	The PSSRS/TSSRS measures the parent/teacher estimate of the child's social skills (control, assertion, and self-control) and problem behaviors (externalizing, internalizing, and hyperactivity). The PSSRS also measures responsibility as part of social skills and the TSSRS provides an estimate of academic competence.
FAMILY MEASURES	
Parent Stress Index (PSI) (Abidin, 1983)	Assesses parent perceptions of stress on the parent-child system. The two main domains are child-related factors and parent factors.
Parent Stress Index Short Form (Abidin, 1990)	A 36-item version of the PSI that provides three scores: parent distress, parent-child dysfunctional interaction, and difficult child.
Family Support Scale (FSS) (Dunst, Jenkins, & Trivette, 1984)	Assess the availabilty of sources of support as well as the degree to which different sources of support provided are perceived as helpful to families rearing young children.
Family Resource Scale (FRS) (Dunst & Leet, 1985)	Assess the extent to which different types of resources are perceived as adequate in households with young children. Factors include: General Resources, Time Availability, Physical Resources, and External Support.
Family Inventory of Life Events and Changes (FILE) (McCubbin, Patterson, & Wilson, 1983)	Assess life events and changes experienced by a family unit during the past 12 months. The specific areas of potential strain covered by the scale include: intra-family, martial, pregnancy and childbearing, finance and business, work-family transitions, illness and family "care," losses, transitions "in and out," and legal.
Family Adaptation and Cohesion Evaluation Scale - III (FACES)(Olson, Portner, & Lavee, 1985)	Provides a general picture of family functioning by assessing the family's level of adaptability and cohesion. Family cohesion assesses degree of separation or connection of family members to the family. Adaptability assesses the extent to which the family system is flexible and able to change in various situations. The scale also has a perceived as well as ideal form that provides an indication of the extent to which current family functioning is consistent with the family's expectations for ideal family functioning.
Parent-Infant Interaction Videotape	Semi-structured play session which could subsequently be scored by raters "blind" to experimental group of child.

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Results and Discussion

Effects of Early versus Delayed Intervention: First Through Third Reassessments

Comparability of samples. The purpose of this study was to examine the effectiveness of an early, intensive motor intervention and subsequent comprehensive developmental intervention compared to a delayed comprehensive developmental intervention for a group of infants at risk for developmental delays because of a history of intraventricular hemorrhage and/or very low birthweight. Comparability of groups on pretest measures, demographics, and medical variables was re-assessed conducted annually to insure that samples were truly representative of original population and to rule out pretreatment group differences.

Table 6.8 summarizes the analyses of the comparability of first-reassessment (12 mo.) groups on the pretest child and family functioning measures. There were no statistically significant differences on any of the pretest measures of infant development or family functioning. Table 6.9 makes the same comparisons for the 58 subjects at the second reassessment. Because only one subject was lost from the second to the third reassessment, these analyses are presented in Table form only for the first and second reassessment population. Comparable analyses for the incomplete samples at fourth, fifth, and sixth post-tests are reported in later sections. It was concluded in all analyses that random assignment had successfully produced equivalent populations, and that attrition had not adversely affected the comparability or representative nature of the study samples.

Table 6.8

Comparability of Groups on Pretest Measures for 64 subjects in SC IVH-Year One Analyses

	Delayed Intervention			Early Intervention					
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	ANCOVA F	p Value	ES♣
•Battelle Developmental Inventory (BDI)									
Raw Scores for:									
Personal/Social	16.4	(5.5)	30	17.2	(5.3)	34	.41	.52	-.15
Adaptive Behavior	12.1	(5.1)	30	12.2	(5.4)	34	.01	.92	.02
Motor	12.1	(5.1)	30	12.0	(4.3)	34	.01	.94	-.02
Communication	8.5	(3.1)	30	8.3	(3.1)	34	.03	.86	-.06
Cognitive	5.6	(3.6)	30	5.6	(2.5)	34	.00	.95	.00
TOTAL	56.0	(20.2)	30	54.2	(15.4)	34	.17	.68	-.09
•Parenting Stress Index (PSI)									
Child Related	109.9	(20.3)	20	113.9	(13.9)	28	.68	.41	-.20
Other Related	119.0	(24.6)	20	126.1	(26.5)	28	.89	.35	-.29
TOTAL	228.9	(40.3)	20	239.9	(36.5)	28	.99	.33	-.27
•Family Adaptation and Cohesion Evaluation Scales (FACES)									
Adaptation	23.4	(7.8)	18	23.1	(7.0)	26	.02	.89	-.04
Cohesion	39.3	(5.5)	18	37.5	(6.8)	26	.89	.35	-.33
•Family Resource Scale (FRS)♠	119.9	(17.3)	16	125.1	(54.1)	26	.14	.71	.30
•Family Support Scale (FSS)♠	11.1	(5.7)	18	11.2	(10.6)	26	.00	.97	-.02
•Family Index of Life♠ Events and Changes (FILE)	31.3	(13.8)	18	26.8	(12.3)	26	1.31	.26	-.33

♣ Effect Size (ES) is defined here as the difference between the groups (Early minus Delayed) means, divided by the unadjusted standard deviation of the Delayed Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size)

♠ Analyses for the FSS, FRS, and FILE are based on raw scores indicating the number of Supports, Resources, and stressful life events occurring.

Table 6.9

Comparability of Groups on Pretest Measures for 58 subjects in SC IVH-Year Two Analyses

Variable	Delayed Intervention			Early Intervention			ANCOVA F	p Value	ES♣
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n			
•Battelle Developmental Inventory (BDI)									
Raw Scores for:									
Personal/Social	16.6	(5.4)	27	17.2	(5.2)	31	.19	.67	.11
Adaptive Behavior	11.9	(5.0)	27	11.8	(5.5)	31	.00	.96	-.02
Motor	12.0	(4.1)	27	12.0	(4.4)	31	.00	.98	.00
Communication	8.5	(3.0)	27	8.3	(3.2)	31	.10	.75	-.07
Cognitive	6.0	(3.6)	27	5.7	(2.6)	31	.12	.73	-.08
TOTAL	56.1	(18.7)	27	53.7	(15.3)	31	.29	.59	-.13
•Parenting Stress Index (PSI)									
Child Related	108.1	(19.8)	18	114.6	(13.9)	25	1.61	.21	-.33
Other Related	119.3	(25.0)	18	127.3	(23.5)	25	1.13	.29	-.32
TOTAL	227.4	(39.4)	18	241.8	(33.0)	25	1.67	.20	-.37
•Family Adaptation and Cohesion Evaluation Scales (FACES)									
Adaptation	23.5	(7.8)	16	22.0	(6.5)	23	.39	.54	-.39
Cohesion	39.1	(5.6)	16	36.3	(6.4)	23	1.93	.17	-.50
•Family Resource Scale (FRS)♦	119.4	(18.8)	16	122.9	(57.3)	23	.05	.83	.19
•Family Support Scale (FSS)♦	10.1	(5.5)	16	11.9	(11.2)	23	.35	.56	-.33
•Family Index of Life♦ Events and Changes (FILE)	31.1	(13.4)	16	25.9	(12.2)	23	1.56	.22	-.39

♣ Effect Size (ES) is defined here as the difference between the groups (Early minus Delayed) means, divided by the unadjusted standard deviation of the Delayed Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size)

♦ Analyses for the FSS, FRS, and FILE are based on raw scores indicating the number of Supports, Resources, and stressful life events occurring.

Reassessments #1-#3

Selection of covariates. The effects of the earlier intervention program on child and family functioning were analyzed using one-way analyses of covariance (ANCOVA). ANCOVA procedures were employed for two purposes: (a) to increase the statistical power of the analyses by reducing error variance; and (b) to statistically adjust for any pretreatment differences between the groups. As noted in description of the subjects, (Table 6.2), there were several potentially clinically significant medical variables which varied at statistically non-significant levels between groups. Because of their potential impact, these medical factors were added into a Medical Severity Index (MSI) score, which was computed for each subject as summarized in Figure One, and was entered as a covariate on all subsequent analyses.

Analyses of outcomes. Table 6.10 summarizes the results from the first reassessment analysis (12 months). At this point, only the "Early Intervention" group had received intervention. The results of the analyses of the child and family measures indicated that after 9 months of intensive motor oriented intervention, the infants in the Early Intervention group had made less progress than control subjects in several developmental domains. It is particularly important that, according to non-adjusted means, the infants were doing more poorly in the gross motor and overall motor areas even though the intervention during the first year was specifically targeted to motor development. When MSI was covaried, the significance of this differences favoring "delayed intervention" subjects disappeared. Parent report on the MCDI was consistent with the Battelle in showing few statistically significant differences but marked trends in the direction of delayed (no) intervention subjects being described as more advanced (on average, "normal" for chronological age) compared to those in early intervention with Physical Therapist (PT) in year one. Analysis of family measures showed virtually no difference between the Delayed (no) Intervention and Early Intervention subjects. Although not tabled, group comparison of parent-infant interaction dimensions as rated on the Parent-Caregiver Involvement Scale (PCIS) revealed no significant differences between groups.

The same analysis procedure was followed for the second reassessment which was given at 24 months of age. Fifty-eight infants received this reassessment. The results of the analyses of the child and family measures are presented in Table 6.11. At the second reassessment, there were no significant differences between the two groups on the Battelle Developmental Inventory, on the MCDI, or on any of the family

Table 6.10

First Reassessment (12 month) Measures of Child & Family Functioning for Delayed (no) Intervention Group vs. Early Intervention Group for SC-IVH Study, with Medical Severity Index (MSI) as Covariate

	Delayed (No) Intervention				Early Intervention						
Variable	$\bar{x}$	(SD)	Adj. X	n	$\bar{x}$	(SD)	Adj X	n	ANCOVA F	p value	ES◆
• **Battelle Developmental Inventory (BDI)**											
Raw Scores for:											
Personal/Social	39.3	(10.3)	38.6	30	34.6	(9.8)	35.2	34	1.81	.18	-.33
Adaptive Behavior	32.2	(7.6)	31.7	30	30.5	(7.4)	30.9	34	.15	.70	-.11
Gross Motor	29.1	(10.6)	28.3	30	24.6	(8.9)	25.3	34	1.53	.22	-.28
Fine Motor	15.5	(6.0)	15.2	30	14.0	(4.6)	14.3	34	.44	.51	-.15
Motor	44.5	(15.6)	43.5	30	38.3	(12.5)	39.3	34	1.41	.24	-.27
Total Communication	22.4	(6.2)	22.0	30	19.4	(5.9)	19.8	34	2.00	.16	-.35
Receptive	11.2	(2.8)	11.0	30	9.5	(3.2)	9.6	34	3.45	.07	-.50
Expressive	11.2	(3.9)	10.9	30	10.0	(3.1)	10.2	34	.59	.45	-.18
Cognitive	18.1	(5.8)	17.7	30	17.7	(4.9)	18.0	34	.08	.78	.05
TOTAL RAW	156.5	(42.5)	153.5	30	140.6	(35.9)	143.1	34	1.10	.30	-.24
• **Minnesota Child Development Inventory (MCDI)◆**											
General Development	93	(31)	91	26	84	(28)	85	31	.61	.44	-.19
Gross Motor	90	(30)	88	26	79	(24)	81	31	.87	.36	-.23
Fine Motor	89	(26)	87	26	85	(31)	85	31	.12	.73	-.08
Express.Language	91	(28)	89	26	88	(21)	89	31	.00	.95	0.00
Conceptual Comprehension	99	(45)	96	26	86	(25)	89	31	.59	.45	-.16
Situation Comprehension	92	(33)	88	26	82	(29)	84	31	.26	.61	-.12
Self-Help	100	(43)	99	26	86	(28)	88	31	1.22	.27	-.26
Personal Social	95	(33)	94	26	81	(24)	81	31	2.60	.11	.50
• **Parenting Stress Index (PSI)**											
Child Related	110.1	(23.1)	112.0	27	110.9	(20.9)	112.5	33	.01	.94	-.02
Other Related	122.8	(27.5)	123.6	27	125.1	(35.1)	126.5	33	.09	.76	-.11
TOTAL	232.9	(46.2)	235.6	27	236.5	(50.7)	239.1	33	.06	.81	-.08
• **Family Adaptation and Cohesion Evaluation Scales (FACES)**											
Adaptation	21.6	(6.0)	21.4	21	21.6	(7.1)	21.8	30	.04	.85	.07
Cohesion	35.8	(7.5)	35.7	21	37.1	(8.6)	37.2	30	.38	.54	.20
• **Family Resource Scale (FRS)◆**	117.3	(17.2)	117.6	22	116.6	(23.9)	117.7	31	.00	.98	.01
• **Family Support Scale (FSS)◆**	30.6	(14.2)	30.4	22	28.3	(13.1)	28.5	30	.24	.63	-.13
• **Family Index of Life◆ Events and Changes (FILE)**	8.8	(7.5)	7.5	20	8.8	(6.5)	9.8	28	.78	.38	.31

◆ Effect Size (ES) is defined here as the difference between the groups (Early minus Delayed) Adjusted means, divided by the unadjusted standard deviation of the Delayed Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size), except for PSI, on which direction is reversed.

◆ Scores were calculated by computing a ratio of developmental score in months/chronological age in months.

◆ Analyses for the FSS, FRS, and FILE are based on raw scores indicating the number of Supports, Resources, and stressful life events occurring.

Table 6.11

Second Reassessment (24 month) Measures of Child & Family Functioning for Delayed (no) Intervention Group vs. Early Intervention Group for SC-IVH Study, with Medical Severity Index (MSI) as Covariate

	Delayed Intervention				Early Intervention						
Variable	$\bar{x}$	(SD)	Adj. X	n	$\bar{x}$	(SD)	Adj X	n	ANCOVA F	p value	ES*
• **Battelle Developmental Inventory (BDI)**											
Raw Scores for:											
Personal/Social	67.3	(16.4)	66.7	27	63.5	(17.1)	64.1	31	.34	.57	-.16
Adaptive Behavior	51.5	(12.7)	50.9	27	47.9	(11.4)	48.4	31	.63	.43	-.20
Gross Motor	45.6	(11.7)	44.9	27	40.7	(15.3)	41.3	31	.96	.33	-.31
Fine Motor	25.2	(7.4)	24.9	27	24.6	(7.4)	24.8	31	.00	.99	-.01
Motor	70.8	(18.0)	69.8	27	65.3	(21.3)	66.2	31	.47	.50	-.20
Total Communication	34.4	(8.0)	34.0	27	31.3	(9.1)	31.6	31	1.04	.31	-.30
Receptive	14.2	(2.9)	14.1	27	13.4	(3.3)	13.4	31	.59	.45	-.24
Expressive	20.2	(5.9)	19.9	27	17.9	(6.2)	18.2	31	1.10	.29	-.29
Cognitive	25.6	(7.2)	25.2	27	22.9	(6.0)	23.2	31	1.38	.25	-.28
TOTAL RAW	247.4	(57.6)	244.6	27	230.8	(57.6)	233.3	31	.55	.46	-.20
• **Minnesota Child Development Inventory (MCDI)'**											
General Development	94	(26)	93	26	87	(28)	88	31	.41	.53	-.19
Gross Motor	104	(41)	103	26	87	(37)	88	31	2.05	.16	-.37
Fine Motor	104	(34)	103	26	95	(26)	96	31	.77	.39	-.21
Express.Language	95	(26)	93	26	91	(25)	93	31	.01	.91	0.00
Conceptual Comprehension	95	(26)	94	26	94	(32)	94	31	.01	.94	0.00
Situation Comprehension	100	(40)	99	26	91	(25)	91	31	.74	.40	-2.40
Self-Help	103	(42)	103	26	95	(32)	96	31	.45	.51	-1.70
Personal Social	94	(32)	92	26	90	(27)	90	31	.04	.84	-.06
• **Parenting Stress Index (PSI)**											
Child Related	109.0	(19.4)	108.9	27	111.3	(22.1)	111.5	31	.21	.65	-.13
Other Related	118.4	(22.20	118.3	27	129.0	(27.5)	129.1	31	2.51	.12	-.49
TOTAL	227.4	(37.0)	227.0	27	239.4	(43.6)	239.7	31	1.32	.23	-.34
• **Family Adaptation and Cohesion Evaluation Scales (FACES)**											
Adaptation	22.0	(5.8)	21.9	27	20.2	(5.7)	20.3	31	1.12	.30	-.28
Cohesion	38.1	(6.1)	37.9	27	36.4	(7.9)	36.6	31	.50	.48	-.21
• **Family Resource Scale (FRS)'**	115.7	(19.4)	115.7	26	112.2	(20.6)	112.2	30	.41	.52	-.18
• **Family Support Scale (FSS)'**	31.7	(14.7)	32.6	27	27.0	(11.6)	27.0	31	2.56	.12	-.38
• **Family Index of Life' Events and Changes (FILE)**	8.4	(6.2)	6.8	27	10.0	(10.4)	9.4	30	.63	.43	-.42

(continued)

♣ Effect Size (ES) is defined here as the difference between the groups (Early minus Delayed) Adjusted means, divided by the unadjusted standard deviation of the Delayed Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size), except for PSI on which direction is reversed.

♦ Scores were calculated by computing a ratio of developmental score in months/chronological age in months.

♦ Analyses for the FSS, FRS, and FILE are based on raw scores indicating the number of Supports, Resources, and stressful life events occurring.

measures. Although there were no statistically significant differences between the groups, it was noteworthy that the delayed intervention group had lower scores on the Parenting Stress Index for non-child-related stress (ES = -.49), reported more social support on the FSS (ES = .38), and reported fewer major life events (ES = -.42) compared to early intervention subjects.

The third reassessment (36 months) showed a similar pattern in the progress of delayed vs. early intervention participants. Again, there were no significant differences between delayed and early on any of the outcome measures, including parent-infant interaction (not tabled). The trends noted at the second reassessment for the early intervention group, to show more stress and less support, were not seen for the most part at this reassessment, though FSS scores still varied somewhat (ES = -.39). These results are summarized in Table 6.12.

Effects of Early vs. Delayed Intervention: Reassessments #4-#6 (Incomplete Samples)

Sample characteristics. Preliminary analyses were conducted in similar fashion to examine the likely direction of outcomes at the fourth, fifth, and sixth reassessments. In examining these results, it is important to note the following: During a funding shortage, 16 subjects did not receive the 54 month fourth reassessment, but returned for the 66 month evaluation once funding was available. Thus, only 37 subjects (16 Delayed Int., 21 Early Int.) were re-assessed at the 54 month level. The 16 subjects who missed the 54 month evaluation during the funding gap were the oldest subjects, first enrolled and first to reach the 66 month reassessment.

T-test comparisons demonstrated that the 54 month sample did not differ significantly from the populations who missed or failed to return for this assessment on any medical, demographic, and pre-test variables with one exception. More of the

Table 6.12

Third Reassessment (36 month) Measures of Child & Family Functioning for Delayed (no) Intervention Group vs. Early Intervention Group for SC-IVH Study, with Medical Severity Index (MSI) as Covariate

	Delayed Intervention				Early Intervention						
Variable	$\bar{x}$	(SD)	Adj. $\bar{X}$	n	$\bar{x}$	(SD)	Adj $\bar{X}$	n	ANCOVA F	p value	ES♣
• **Battelle Developmental Inventory (BDI)**											
Raw Scores for:											
Personal/Social	94.7	(27.5)	93.7	27	89.6	(30.0)	90.5	30	.17	.68	-.12
Adaptive Behavior	69.8	(18.4)	69.1	27	62.8	(17.9)	63.5	30	1.30	.26	-.30
Gross Motor	54.0	(15.3)	53.0	27	48.1	(16.6)	49.0	30	.85	.36	-.26
Fine Motor	34.2	(10.3)	33.6	27	30.6	(10.0)	31.1	30	.83	.37	-.24
Motor	88.2	(24.9)	86.5	27	78.6	(25.3)	80.1	30	.92	.34	-.26
Total Communication	44.3	(12.5)	43.9	27	39.8	(13.2)	40.1	30	1.12	.30	-.30
Receptive	17.3	(5.5)	17.2	27	15.4	(6.0)	15.6	30	.97	.33	-.29
Expressive	26.9	(8.0)	26.6	27	24.4	(7.9)	24.6	30	.91	.34	-.25
Cognitive	34.6	(12.2)	34.4	27	31.5	(10.5)	31.7	30	.72	.40	-.22
TOTAL RAW	331.1	(86.5)	327.2	27	302.4	(86.7)	306.0	30	.81	.37	-.25
• **Minnesota Child Development Inventory (MCDI)♦**											
General Development	100	(62)	100	26	87	(45)	89	30	.63	.43	-.18
Gross Motor	94	(50)	93	26	78	(46)	80	30	1.06	.31	-.26
Fine Motor	86	(40)	85	26	77	(34)	78	30	.52	.48	-.18
Express.Language	84	(29)	84	26	83	(35)	84	30	.01	.93	.00
Conceptual Comprehension	93	(36)	92	26	84	(37)	85	30	.52	.47	-.19
Situation Comprehension	94	(45)	93	26	86	(42)	88	30	.19	.66	-.11
Self-Help	100	(50)	99	26	89	(39)	90	30	.51	.48	-.18
Personal Social	85	(39)	83	26	75	(30)	75	30	.76	.39	-.21
• **Parenting Stress Index (PSI)**											
Child Related	116.5	(23.1)	115.9	26	112.3	(23.4)	112.9	30	.23	.64	.13
Other Related	128.3	(23.8)	127.0	26	122.7	(27.4)	123.9	30	.20	.66	.13
TOTAL	244.8	(42.0)	242.9	26	235.1	(43.6)	236.7	30	.28	.60	.15
• **Family Adaptation and Cohesion Evaluation Scales (FACES)**											
Adaptation	22.0	(8.0)	20.8	25	20.4	(6.1)	20.3	29	.07	.80	-.06
Cohesion	36.4	(6.0)	37.0	25	36.7	(8.2)	36.7	29	.02	.89	-.05
• **Family Resource Scale (FRS)♦'**	108.5	(23.7)	108.5	26	111.2	(22.6)	111.2	29	.18	.68	.11
• **Family Support Scale (FSS)♦'**	31.9	(17.4)	32.4	26	26.0	(10.4)	25.6	29	3.13	.08	-.39
• **Family Index of Life♦' Events and Changes (FILE)**	7.5	(5.3)	6.2	26	6.7	(4.9)	7.6	30	.65	.43	.26

♣ Effect Size (ES) is defined here as the difference between the groups (Early minus Delayed) Adjusted means, divided by the unadjusted standard deviation of the Delayed Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size), except for PSI on which direction is reversed.

♦ Scores were calculated by computing a ratio of developmental score in months/chronological age in months.

♦' Analyses for the FSS, FRS, and FILE are based on raw scores indicating the number of Supports, Resources, and stressful life events occurring.

subjects with BPD at birth were not tested than tested. Thus, in spite of small numbers and sample differences, these populations were considered "representative" enough to be providing an accurate sample of data at this assessment interval.

Examination of initial differences within the 54 month sample using a series of T-tests showed one important difference between delayed and early intervention groups on medical, demographic, or pretest scores at 3 months adjusted age. That is, the early intervention subjects had significantly higher medical severity scores than the delayed intervention group. Thus, analysis of covariance, with MSI as covariate, was employed in analysis of the 54 month reassessment data for this sample.

Remarkably, there were no pretreatment differences noted between the delayed and early intervention subjects included in both the 66 and the 78 month reassessments. This was true for medical variables, demographic variables, and pretest variables. While the 78 month evaluations are not yet finished, and there may be variability once the cohort has been completed, outcome analyses for both 66 and 78 month evaluations were conducted at this time with no covariates, using simple t-tests.

Analyses of Outcomes

Table 6.13 summarizes the fourth (54 month) analyses of group differences between the 16 youngsters who originally received earlier intervention (at 3 months adjusted age) and those who received delayed intervention beginning at 12 months (adjusted age). In this full representative sample, the early intervention group showed significantly poorer performance on motor scales as measured by the Battelle, and tended to receive lower scores on all Battelle subscales. The Stanford Binet scores did not differ for the 18 early intervention subjects who were testable with this instrument compared to the 14 delayed intervention subjects who were testable. Furthermore, there were no differences on family measures, though parents of early intervention subjects tended to report lower levels of child-related stress.

Table 6.14 summarizes the fifth (66 month) analyses, which employed virtually the same measures. The data collected and analyzed to date suggest that children in the early intervention group continue to score more poorly on standardized measures of development than the delayed intervention group that started intervention at 12 months of age. Particularly striking is the fact that scores on motor development, the target of the earliest intervention sessions, were significantly lower for the early intervention group five years after intervention. While school-aged children in the delayed group scored in the "Average" to "Low Average" range as a group on the Stanford Binet, children in the early group scored in the "Low Average" to "Borderline" Range. There were no measurable differences between the groups on measures of family function.

Although it is not tabled, preliminary examination of additional services data provided a flip side to this finding. Although test scores were better for the delayed group, it is striking that as a group, the early intervention subjects were receiving significantly fewer hours of school than the delayed subjects at the fifth reassessment. While the delayed subjects had averaged 780 hours of headstart or preschool from ages 4 1/2 to 5 1/2, the early subjects reported only 183 ($t\ (41) = 2.06$, $p<.04$). Additional work is needed to check and more carefully examine the data on additional services received by participants in each group. However, if the delayed group is indeed receiving four times the educational services, the cost outcomes may reflect a more favorable picture for early intervention than delayed intervention. Alternatively, the fact that control group children received much more preschool/headstart service may be a context variable for the marked differences on test scores. The relationships between services and other outcomes will be a target of further exploration in the coming year.

Preliminary analyses of the sixth reassessment (78 month) are summarized in Table 6.15. While achievement test data on the Woodcock Johnson tend in a direction that supports the efficacy of delayed intervention, means from measures of adaptive function favor the early intervention group. With behavioral and emotional data still being entered and additional subjects being tested in this year, one can not draw firm conclusions at this time. However, it is possible that these measures will show certain kinds of competencies have been enhanced by earlier intervention, while others have been enhanced by delaying intervention until 12 months of age.

Table 6.13
Fourth Reassessment (54 month) Measures of Child & Family Functioning for Delayed (no) Intervention Group vs. Early Intervention Group for SC-IVH Study, with Medical Severity Index (MSI) as Covariate

	Delayed Intervention				Early Intervention						
Variable	$\bar{X}$	(SD)	Adj. $\bar{X}$	n	$\bar{X}$	(SD)	Adj $\bar{X}$	n	ANCOVA F	p value	ES*
• **Battelle Developmental Inventory (BDI)**											
Raw Scores for:											
Personal/Social	132.3	(39.0)	127.6	16	112.3	(38.0)	115.1	21	1.00	.31	-.32
Adaptive Behavior	88.1	(19.9)	86.7	16	73.9	(23.7)	75.0	21	2.30	.14	-.6
Gross Motor	70.6	(12.8)	69.6	16	54.5	(24.3)	55.3	21	4.10	.05	-1.1
Fine Motor	49.6	(11.3)	48.5	16	39.4	(16.5)	40.2	21	2.80	.10	-.7
Motor Total	120.3	(23.7)	118.3	16	94.0	(39.5)	95.4	21	3.80	.06	-1.0
Communication											
Receptive	25.9	(8.8)	23.3	16	20.5	(7.6)	21.0	21	2.30	.14	-.26
Expressive	35.9	(8.4)	34.8	16	31.1	(13.3)	32.0	21	.60	.46	-.33
Total	61.8	(16.5)	60.1	16	51.6	(20.3)	52.9	21	1.30	.27	-.44
Cognitive	54.8	(22.2)	53.2	16	45.3	(17.0)	46.5	21	1.00	.323	-.30
Battelle Total	457.2	(111.4)	446.7	16	377.1	(126.2)	385.0	21	2.20	.14	-.55
• **Stanford-Binet**											
Verbal Reassurance	89.0	(18.6)	88.1	14	83.2	(12.9)	84.0	18	.48	.49	-.22
Abs. Vis.	94.2	(16.1)	94.3	14	89.9	(11.8)	89.8	18	.74	.40	-.28
Quantitative	86.1	(41.0)	82.8	14	87.8	(28.0)	90.3	18	.37	.55	.18
Short-term Memory	90.1	(14.5)	91.7	14	95.8	(64.8)	94.6	18	.02	.88	.2
Composite	91.4	(19.1)	90.6	14	85.6	(11.3)	86.3	18	.57	.45	-.23
• **Family Resource Scale (FRS)**	108.7	(16.7)	108.5	13	114.8	(28.1)	114.9	20	.51	.48	.38
• **Family Support Scale (FSS)**	27.8	(12.0)	28.2	15	26.5	(13.1)	26.3	21	.22	.64	-.16
• **Parenting Stress Index (PSI)**											
Child Related	113.7	(20.5)	113.8	15	104.1	(18.2)	103.9	21	1.95	.17	-.48
Other Related	125.1	(23.4)	123.2	15	117.7	(25.7)	119.1	21	.22	.65	-.18
TOTAL	238.8	(37.5)	237.1	15	221.8	(39.4)	223.0	21	1.00	.32	-.38

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Table 6.14

Fifth Reassessment (66 month) Measures of Child & Family Functioning for Delayed (no) Intervention Group vs. Early Intervention Group for SC-IVH Study

	Delayed Intervention			Early Intervention						
Variable	$\bar{X}$	(SD)	n	X	(SD)	n	+	p value	df	ES
• **Battelle Developmental Inventory (BDI)**										
Raw Scores for:										
Personal/Social	143.3	(41.3)	20	134.9	(33.7)	28	.78	.44	46	-.20
Adaptive Behavior	92.9	(29.1)	20	86.9	(24.5)	28	.78	.44	44	-.21
Gross Motor	75.9	(17.9)	20	61.5	(26.0)	28	2.27	.03	46	-.80
Fine Motor	58.0	(18.2)	20	48.2	(17.4)	28	1.88	.07	46	-.54
Communication										
Receptive	34.2	(12.1)	20	29.3	(12.2)	28	1.37	.18	46	-.40
Expressive	42.0	(13.3)	20	36.7	(13.4)	28	1.36	.18	46	-.40
Total	76.2	(24.4)	20	66.0	(24.1)	28	1.44	.16	46	-.42
Cognitive	72.1	(28.6)	20	60.0	(24.9)	28	1.57	.12	46	-.42
Battelle Total	518.4	(152.3)	20	457.4	(137.3)	28	1.45	.15	46	-.40
• **Stanford-Binet**										
Verbal Reassurance	92.3	(11.1)	18	86.0	(13.4)	25	1.63	.11	41	-.57
Abs. Vis.	89.9	(17.5)	18	78.5	(15.7)	25	2.25	.03	41	-.65
Quantitative	101.2	(17.2)	17	88.6	(20.1)	22	2.06	.05	37	-.73
Short-term Memory	89.8	(12.2)	18	78.4	(11.5)	24	3.11	.00	40	-.93
Composite	91.6	(14.7)	18	79.3	(15.3)	25	2.64	.01	41	-.84
• **Family Resource Scale** (FRS)	113.8	(19.4)	17	112.4	(21.3)	28	.21	.83	43	-.07
• **Family Support Scaley** (FSS)	25.4	(11.1)	20	27.7	(13.6)	29	-.62	.54	47	.21
• **Parenting Stress Index** (PSI)										
Child Related	106.1	(24.5)	20	106.1	(22.7)	29	.00	1.00	47	0
Other Related	119.4	(27.6)	20	118.0	(28.0)	29	.18	.86	47	-.05
TOTAL	225.5	(46.4)	20	224.1	(48.4)	29	.10	.92	47	-.03
• **Achenbach**										
Externalizing	55.2	12.3	15	51.4	11.6	23	.95	.35	36	-.31
Internalizing	50.7	10.2	15	48.1	11.1	23	.75	.46	32	-.25
Total	56.5	11.3	15	52.4	11.5	23	1.1	.30	30.5	-.36
Number	28.7	17.3	15	23.5	17.0	23	.93	.36	36	-.30
• **CBC Subscales**										
Withdrawn	55.0	7.6	15	54.8	8.2	23	.07	.95	31.7	-.03
Somatic Complaints	56.3	6.4	15	56.7	9.6	23	-.11	.91	36	.06
Anxious/Depressed	53.5	5.9	15	51.7	5.7	23	.96	.34	36	-.31
Social Problems	36.1	26.5	15	29.1	22.5	23	.87	.39	36	-.26
Thought Problems	56.4	8.7	15	57.3	9.4	23	-.29	.77	31.8	.10
Attention Problems	58.8	10.5	15	55.4	7.4	23	1.16	.25	36	-.32
Delinquent Behavior	56.4	8.4	15	55.7	7.3	23	.26	.80	36	-.08
Aggressive Behavior	58.5	10.7	15	55.4	6.7	23	1.1	.27	36	-.29

Table 6.15

Sixth Reassessment (78 month) Measures of Child & Family Functioning for Delayed (no) Intervention Group vs. Early Intervention Group for SC-IVH Study

	Delayed Intervention			Early Intervention						
Variable	$\bar{X}$	(SD)	n	X	(SD)	n	+	p value	df	ES
• **Woodcock-Johnson--Revised**										
Applied Problems	81.7	(20.8)	12	74.5	(27.5)	20	.78	.44	30	-.35
Dictation	89.9	(17.3)	12	75.5	(30.7)	19	1.67	.11	28.0	-.83
Science	91.0	(20.1)	12	83.1	(25.9)	21	.90	.37	31	-.39
Social Studies	93.1	(21.0)	12	82.9	(19.8)	21	1.40	.17	31	-.49
Humanities	91.4	(14.4)	12	81.4	(16.0)	21	1.78	.09	31	-.69
Broad Knowledge	89.9	(16.7)	12	80.0	(21.3)	21	1.39	.17	31	-.59
Broad Skills	86.0	(19.9)	12	75.6	(27.7)	19	1.12	.27	29	-.52
• **Scales of Independent Behavior**										
Motor	64.6	(28.6)	14	67.2	(24.3)	20	-.29	.78	32	.09
Social/Communication	72.2	(36.4)	14	77.3	(26.4)	20	-.47	.64	32	.14
Personal/Living	73.1	(30.7)	14	79.2	(28.6)	20	-.58	.56	32	.20
Community Living	64.2	(26.9)	14	70.7	(19.4)	20	-.82	.42	32	.24
Broad Independence	68.0	(29.4)	14	73.4	(19.0)	20	-.65	.52	32	.18
• **Visual Motor Integration**										
Standard Score	84.4	(12.6)	12	83.0	(15.9)	20	.27	.79	30	-.08
• **Family Resource Scale**	26.6	(14.9)	14	116.7	(29.6)	22	-.52	.61	34	-.66
• **Parent Stress Index**										
Parent Distress	25.9	(6.9)	14	24.4	(5.4)	21	.74	.47	33	-.22
Parent/Child Dysfunction	24.9	(5.7)	14	23.3	(5.2)	21	.81	.42	33	-.28
Total	81.0	(19.0)	14	76.0	(12.7)	20	.92	.36	32	-.26
• **Family Support Scale**	26.6	(14.9)	14	26.4	(13.5)	20	.04	.96	34	.01
• **Achenbach**										
Externalizing	54.6	11.8	14	50.5	10.4	23	1.10	.28	35	-.35
Internalizing	48.9	12.7	14	47.3	11.4	23	.37	.71	35	-.13
Total	52.1	17.6	14	50.7	12.2	23	.30	.77	35	-.08
Number	27.8	16.2	14	20.9	14.7	23	1.3	.19	35	-.43
• **CBC Subscales**										
Withdrawn	55.3	10.3	14	55.0	9.1	23	.09	.93	25	-.03
Somatic Complaints	56.4	8.6	14	53.3	7.0	23	1.2	.25	35	-.36
Anxious/Depressed	51.7	4.8	14	52.5	6.2	23	-.39	.70	35	.17
Social Problems	35.3	28.3	14	25.5	20.5	23	1.1	.27	21.3	-.35
Thought Problems	58.0	12.4	14	56.8	8.2	23	.31	.76	20.0	-.10
Attention Problems	59.7	11.7	14	55.8	8.6	23	1.1	.25	35	-.33
Delinquent Behavior	58.8	9.0	14	53.6	4.8	23	2.3	.03	35	-.58
Aggressive Behavior	57.1	9.9	14	55.0	6.9	23	.79	.43	35	-.21

Comparison to Other Studies

The results of this ongoing longitudinal study suggest that with this population of medically fragile infant (IVH and/or <1000 grams), early motor intervention of the type and intensity utilized here did not provide measurable benefits in the first six years of life. If anything, the groups who did not participate in intervention between 3 and 12 months looked better than their randomly assigned counterparts on key developmental dimensions.

The results of this study concur with those of two earlier studies of sensorimotor intervention (Goodman et al., 1985; Palmer et al., 1988). While there are important methodological differences between this study and those performed previously, the pattern of results begins to suggest that early intervention which is directed mainly toward facilitation of motor development in the first year of life may not provide significant advantage over broader intervention beginning at one year with this population, even though developmental theory would say that sensorimotor development should be the primary focus at this age. It remains to be seen whether interventions that are more broadly based and are more intensive would be effective in preventing or remediating developmental problems. The study described below addressed this issue.

The largest set of studies other than the one reported in this volume that has examined intervention outcomes to this extent is the Infant Health and Development Program (Infant Health and Development Program, 1990). A direct comparison between this study and IHDP is difficult because most of the participants in this study would have been excluded from or examined separately in IHDP. Also, the intervention implemented in IHDP was much more intensive and costly. Nevertheless, the findings of the projects provide some perspective on the present findings.

In the Infant Health and Development Program, significant group differences were not reported at 12 months or 24 months between control groups and groups receiving much more expensive comprehensive full day, five day per week programming. At year three, significant differences existed in group means, with the exception of the "lighter" infants (< 1500 g). In the present study, only 8% of the participants weighted more than 1500 g at birth, and approximately half weighed less than 1000 grams. The IHDP's lighter and more delayed infants did not benefit significantly from the very intensive intervention program. In this context, it is not so surprising that we cannot document earlier intervention benefits in our medically fragile sample. Perhaps even more heroic interventions are needed for this population.

In an effort to replicate some of the logic and methodology employed in the seminal work of the IHDP, we conducted separate analyses of our lower birthweight and higher birthweight infants to see if our study could find a similar trend of bigger, healthier infants showing greater benefit. Again, direct replication was impossible: only 82 of IHDP's 908 participants weighed <1800 grams; only 5 of our 57 third reassessment participants weighed OVER 1800 grams.

For our analyses, 24 subjects weighing <1000 grams (extremely low birthweight - ELBW) were examined separately from 23 weighing >1000 grams (very low birthweight - VLBW) for t-test group comparison major outcome variables at 36 months. There were no group differences for either the ELBW or VLBW samples. Further analyses of this sort will be conducted in the coming year to enhance our understanding of the role birth variables may have played in this medically fragile, culturally diverse sample that is virtually unique in the intervention literature.

In interpreting the present findings one must also consider that all subjects had some sort of intervention, and the design of this study may not have provided sufficient contrast to highlight the age-of-start question properly. Boyce and her colleagues (Boyce et al. 1993) compared similar intervention right out of the NICU with broader intervention which started at 18 months adjusted age. As her sample matures, there is some evidence that long term advantages may have been achieved in her earlier group compared to those who started at 18 months. It should also be noted that as a group both this sample and the Boyce et al (1993) sample have been scoring better on standardized tests of development than previous literature would have suggested for this population.

Although the age-at start question has not been definitively answered with these data, this is a rich data set which allows for exploration of several questions directly relevant to intervention outcomes, as well as questions dealing with constructs of stress, parent interaction, and measurement of outcomes which are theoretically and empirically important to our progress with the medically fragile population. In subsequent sections, additional lines of inquiry which have been conducted and/or are underway with this data set will be described.

Treatment Compliance Analyses

Parent interviews were completed in 1990-91 as part of an additional treatment verification process. Although much of this data is difficult to quantify, initial review of interview data and interventionist records were utilized to allow for preliminary examination of parent participation as a factor in these results.

The project director and research coordinator independently assigned subjects to one of four treatment categories based on their participation: (1) subjects assigned to early intervention who completed both 12 and 24 months with good compliance (Early/Comply); (2) subjects assigned to early intervention who withdrew or failed to comply with both parts (Early/Non-comply); (3) subjects assigned to Delayed who participated fully once they were invited to be in intervention in Year 2 (Delayed/Comply); and (4) subjects assigned to Delayed who dropped out prematurely or failed to participate meaningfully (Delayed/Non-comply). Independent raters agreed on 61 of 64 category assignments, then agreed on the assignment of three whose status was first ambiguous.

A 2 x 2 ANOVA was utilized to compare the four groups' developmental and family outcomes at two and three year reassessments (Year 1 was omitted since delayed subjects had not yet had an opportunity to become compliers vs. non-compliers at this assessment). There were no significant differences between groups or between compliers and noncompliers, and there were no significant interactions on any of the variables. Thus, there were no measurable differences among assignment or compliance groups.

A second set of analyses selected only early intervention subjects in "comply" group and compared them to delayed intervention subjects regardless of compliance status. For this analysis, seven subjects were removed, regardless of group based on their profound disabilities and sensory impairments making their potential for intervention responsiveness different from that of the remaining sample. When this group of consistently participating early intervention subjects was compared to delayed subjects, there were no significant differences on developmental or family measures. The means of the early intervention subjects, however, were consistently lower than those of delayed intervention subjects on developmental measures.

These results suggest that the early delivery of this type and intensity of treatment to this population did not provide a measurable advantage over delayed intervention. Furthermore, subjects who self-selected to become non-participants or very infrequent participants for whatever reasons (at least some of these subjects felt they did not need intervention because problems were not evident) did not progress differently than subjects in either delayed or early intervention.

Predictors of Developmental Progress

Since age of start for intervention and extent of participation in intervention did not significantly predict developmental progress, we spent the last year seeking to answer the question, "What DID predict developmental progress?" Factors commonly implicated in the literature as correlates of development were entered into a stepwise multiple regression to see which would predict child development as measured on the Battelle and MCDI at 12 month, 24 month, and 36 month adjusted ages. Mother education, income, race, Medical Severity Index (MSI) score, Average Appropriateness score from 12 month PCIS (Parent-Child Interaction) and intervention group status were entered without pre-specified order to determine their power to contribute to the variance in development, as measured by the MCDI and the Battelle.

At 12 months, mother education was the only significant predictor of child development on the Battelle (t = 3.03, $p < .004$), though MSI approached significance ($p < .09$). At 24 month and 36 month reassessments, only maternal education was a significant predictor of MCDI or Battelle. The problems inherent in using the MCDI (parent report) as the developmental outcome seem less significant in light of the replication of the finding using the Battelle scale. Table 6.15 summarizes the correlations between key medical/demographic variables and developmental scores at 12, 24, and 36 months. Both Medical Severity Index (MSI) and maternal education correlated with development at 12 months, while only maternal education predicted development at 24 and 36 month intervals. Relationships are summarized in table 6.16.

Table 6.16

Correlations of Key Demographic and Medical Variables with Developmental Scores in First 36 months (for all SC subjects)

	12 Months		24 Months		36 Months	
Variable	Battelle Total	MCDI GD	Battelle Total	MCDI GD	Battelle Total	MCDI GD
Income	.13	.05	.07	.07	.20	.23
Mother Education	$.36^b$	$.38^b$	$.32^a$	$.26^a$	$.42^a$	$.41^b$
Race	-.03	.01	.01	-.02	-.03	.00
Group (Delayed vs. Early)	-.11	-.10	-.12	-.07	-.14	-.11
Parent Interest (PCIS Approp)	-.11	.01	.01	$-.31^a$	-.13	.04
Medical Severity	$-.32^b$	-.24	-.23	-.18	-.21	-.11

^{a} = $p < .05$ ^{b} = $p < .01$ ^{c} = $p < .001$

Predictors of Development in Combined Sample: SC and SLC

This year we were able to further explore potential predictors of development by combining data from the South Carolina and Salt Lake City samples of youngsters with IVH. In the combined sample there were 98 children with both the Binet and Battelle scores as developmental outcomes for the third reassessment, and 86 with both measures for the fourth reassessment. The larger, more culturally diverse sample provided an opportunity to examine a wide range of medical, demographic, and psychological variables as predictors of developmental outcomes at each reassessment. Initial regression analyses were constructed to identify significant predictors among the demographics, among the medical variables, and among the psychological variables. Age of start was also re-examined as a predictor of outcomes. A subsequent regression then combined the significant predictors from each cluster to determine the most potent predictors of developmental outcomes. Outcomes were represented two different ways: the IQ score from the Binet represented the developmental level achieved in standardized terms and the difference score between the Battelles at reassessment one (when all youngsters enrolled in intervention) and either third or fourth reassessments represented a barometer of "developmental progress", in which each child was compared to himself versus others.

Of the potential biological/medical predictors- gender, birthweight, days of ventilation in the NICU, total length of hospital stay, "temperament" (as reflected in child-related stress on 3 month PSI), and a composite medical problems score- there were no significant predictors or correlates of developmental change (Battelle change score) or developmental outcome (Binet) at either year three. The medical problem score was the one significant medical variable, predicting both Battelle change and Binet level, at year four.

Potential psychological predictors included parent-related parenting stress as reported on the PSI, change in social support during the two year period, and change in financial resources (or perceived adequacy of resources) on the FRS. Change in family support correlated with Binet IQ at three years, in an unexpected direction. Families whose children achieved a higher IQ were more likely to report declines in social support, a finding similar to that in our parent interaction and resource studies reported later.

Of the potential demographic factors- family composition, income, maternal age, maternal income, and maternal ethnicity- both maternal education and ethnicity predicted developmental outcomes at years three and four. Children of more educated mothers were more likely to show developmental gains between the ages of one and three (though no relationship was noted between education and year four outcomes). Maternal ethnicity was a significant predictor of Binet IQ at both 3 and 4 year assessments. In fact, of all the variables examined, only ethnicity predicted four year outcomes.

The final regression analyses are overviewed in Table 6.17. These findings will be refined, checked and thoughtfully considered in preparation for their presentation at the 1994 DEC conference in St. Louis.

Table 6.17
Correlates of IQ and Developmental Progress for 98 Medically Fragile Youngsters from South Carolina and Salt Lake City Sites

Variables	Third Reassessment		Fourth Reassessment	
	Year 3 Binet IQ	Battelle Chg Year 1 to 3	Year 4 IQ	Battelle Chg Year 1 to 4
Medical Variables				
Birthweight	.11	.05	.10	.01
Days in Hospital	-.14	-.10	-.13	-.15
Days on Ventilator	-.05	-.08	-.07	-.15
Number of Medical Problems	-.10	-.03	-.22	-.19
Gender	.15	.15	.06	.12
PSI Child Stress	-.01	-.15	-.23	-.22
Demographic Variables				
Family Composition	.27[b]	.02	.17	-.09
Income at Reassessment Year	.41[c]	.33[c]	.24[a]	.27[a]
Income when Enrolled	.36[c]	.29[b]	.18	.16
Mother Education	.19	.27[b]	.07	.21[a]
Mother Age	-.00	-.02	-.14	.00
Psychological Variables				
Family Resources at Reassessment	.28[b]	.29[b]	.23[a]	.19
Change in Resources	.07	.15	.01	.11
Family Support at Reassessment	-.02	.01	-.01	.00
Change in Supports	-.24[a]	.05	-.19	.06
Parent Stress at Reassessment	.09	.70	.13	.02

[a] $p < .05$
[b] $p < .01$
[c] $p < .001$

Parent-Child Interaction and Development

An earlier study based only on partial samples prompted us to wonder whether participating in earlier intervention may have altered parent-child interaction in ways known to enhance development. This was particularly a concern in the first two years of life when parent-child exchanges tend to be crucial factors.

In the case of this study, examination of this issue at the first (12 month) reassessment was actually a comparison involving an "intervention", and a "no intervention" group. At the 12 month assessment there were significant correlations between parent perception of child development (MCDI) and dimensions of parent child interaction (Appropriateness and Quality scores on PCIS) in the non-intervention or delayed group, as one would expect in the population as a whole. However, there were no such relationships between interaction and development in the group that had been in the early sensorimotor intervention. Bearing in mind that the groups did not differ from one another on either developmental scores or parent-interaction, this is an intriguing finding. Perhaps our introduction of structured activities to be performed daily by the parents disrupted the normally occurring interactions in ways that at least in the short run inhibited or sidetracked these processes.

In year two, when all participants had a year of intervention that was more broad in focus and more family centered, this pattern was again repeated. Results of these correlational studies are summarized on Table 6.18. Implications of these findings and the possibility that they might facilitate interpretation of early findings have been explored, but have not been fully examined as scoring of some parent-child interaction data is still pending.

Related Studies in this Data Set

In addition to core research presented and discussed, this longitudinal data set with an understudied population has provided opportunities for ancillary studies at various stages of progress. Lines of research and status of each are briefly presented below:

A) Relationship of maternal responsivity and parenting stress. A recent graduate of University of Florida at Gainesville and MUSC's Clinical Internship, Beth Onufrak, has worked with us again this year in examining the determinants of parent responsiveness in two year-olds. Her preliminary study, which demonstrated a positive correlation between PSI child stress and PCIS Appropriateness scale in 40 dyads from the SC site, won MUSC's 1992 prize for Best Intern paper (of 14 submitted for blind review) and was presented at the Gainesville Conference on Pediatric Psychology in April 1993 (University of Florida-Gainesville). She subsequently developed this into a Dissertation study which includes data from SLC-IVH. Her study with 99 dyads at 24-30 months of age yielded mixed support for the hypothesis that parenting stress and maternal responsivity are related in this population. Furthermore, she documented that demographic variables (and, to a lesser extent, medical variables) in this data set had more power to predict maternal responsivity than other variables thought to be theoretically relevant. Issues of ethnicity and instrumentation were thoughtfully examined in her full Dissertation and a paper presented at the Southeastern Psychological Association meeting in March of 1994. Since her successful defense on September 13, 1993, we have collaborated with Dr.

Table 6.18

Correlations Between quality and Appropriateness of Parent-Child Interaction on PCIS and Developmental Outcomes for Early vs. Delayed Groups

	Delayed		Early	
	r	n	r	n
Year One				
MCDI and Appropriateness	-.54*	20	-.18	29
MCDI and Quality	-.48	20	-.11	29
Battelle and Appropriateness	-.18	21	-.10	31
Battelle and Quality	-.09	21	-.02	31
Year Two				
MCDI and Appropriateness	-.46	24	-.14	28
Quality	-.45	24'	-.02	28
Battelle and Appropriateness	-.38	25	.02	28
Quality	-.46	25	-.01	28

* MCDI = Parent report of development on Minnesota Child Development Inventory; Battelle = raw TOTAL score on Battelle Developmental Index; Appropriateness = Average rating of Appropriateness for 11 dimensions of maternal behavior as rated on the Parent-Caregiver Involvement Scale (PCIS); Average quality rating on PCIS.

Onufrak on a manuscript draft which was submitted and later revised at the invitation of the Journal of Pediatric Psychology. The Lisrel Path Analysis suggested by the JPP editors and conducted by Dr. Matt Taylor yielded cleaner results than the regression models initially employed, and suggested a method that may be of use in other studies in this data set. Figure 6.2 summarizes the Lisrel Path Analysis conducted for this study.

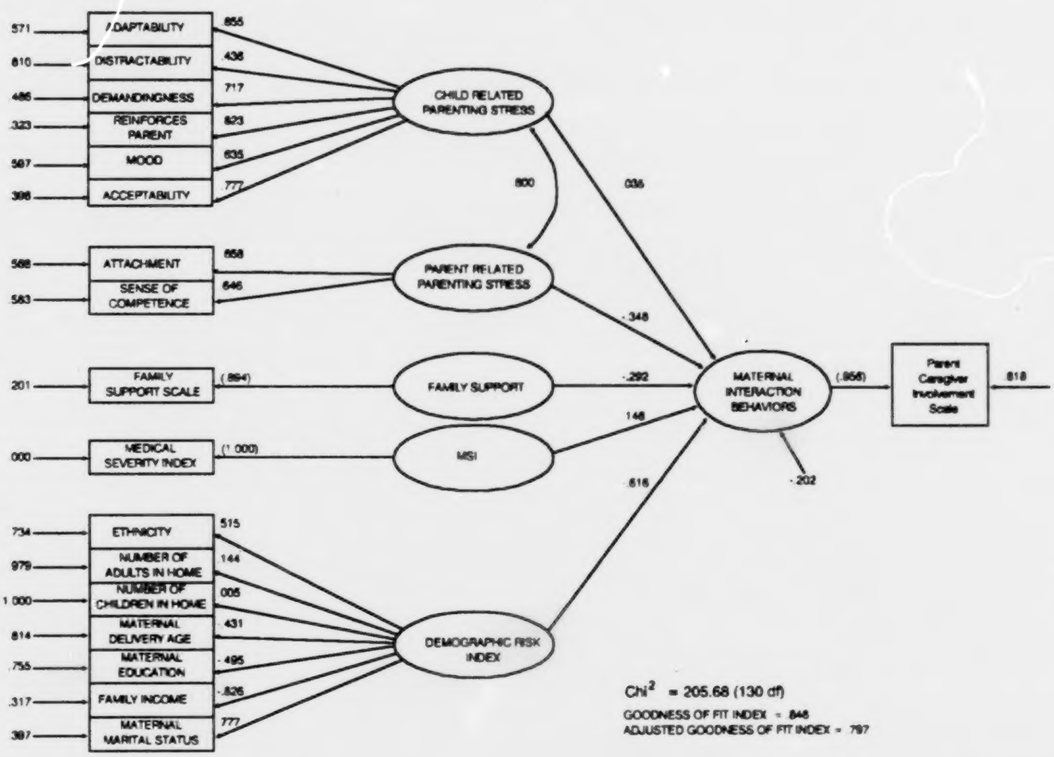
571
ADAPTABILITY
.855
610
DISTRACTABILITY
.436
.486
DEMANDINGNESS
717
.323
REINFORCES PARENT
823
597
MOOD
635
398
ACCEPTABILITY
.777
CHILD RELATED PARENTING STRESS
800
036
568
ATTACHMENT
658
583
SENSE OF COMPETENCE
646
PARENT RELATED PARENTING STRESS
-.348
201
FAMILY SUPPORT SCALE
(.894)
FAMILY SUPPORT
-.292
000
MEDICAL SEVERITY INDEX
(1 000)
MSI
148
MATERNAL INTERACTION BEHAVIORS
(.958)
Parent Caregiver Involvement Scale
818
-.202
.616
734
ETHNICITY
515
979
NUMBER OF ADULTS IN HOME
.144
1 000
NUMBER OF CHILDREN IN HOME
006
814
MATERNAL DELIVERY AGE
-.431
.755
MATERNAL EDUCATION
-.495
.317
FAMILY INCOME
-.826
387
MATERNAL MARITAL STATUS
777
DEMOGRAPHIC RISK INDEX
Chi² = 205.68 (130 df)
GOODNESS OF FIT INDEX = 848
ADJUSTED GOODNESS OF FIT INDEX = 797

Figure 6.2. Lisrel Path Analysis for the South Carolina Medically Fragile Study

B)Ethnicity and Parenting Stress. Another interesting line of research has been pursued this year in collaboration with a Citadel undergraduate, Augustus McDowell. A senior minority student aspiring to attend graduate school, Gus became interested in the issue of parenting stress, and how the determinants of parenting stress might differ for different ethnic groups. Using a correlational design in a combined data

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sample (medically fragile children from SC and Salt Lake samples), we determined that indeed the correlates in parenting stress change during the course of intervention was different for the African-American and Caucasian intervention participants. While failure of the child to progress developmentally and reduction of social supports coincided with increased stress in white parents, income was the only correlate of change in the non-white parents. This small but thoughtful paper was recognized with Honorable Mention in the S.C. Psychological Association's annual Undergraduate Paper competition, and has been accepted for publication in Early Child Development and Care.

C) Social Skills, Behavior Problems, and Language Delays. With the collection of our first five and six year behavioral data, it has been possible to examine behavioral outcomes along with developmental outcomes. Kara van Der Heyden, a special education teacher completing her Ed.S. in School Psychology at the Citadel, became interested in the relationship between language delays and social/behavioral function in the medically fragile population after having some of them in her preschool diagnostic classrooms. Her study, again a correlational study using data from both South Carolina and Salt Lake City sites, suggested that in this population language delays may coincide with behavior problems and social skills deficits in children as they reach elementary school age. Interestingly, we also found that developmental scores at age three could have predicted who would be displaying these social and conduct problems at age five and one half. Kara presented the findings at S.C Psychological Association, winning Honorable Mention in the Graduate Student Paper competition. We have submitted the manuscript version for publication review in a special education journal.

D) Psychometric Issues. Because of its longitudinal, multimethod design, this study has provided a wealth of data about measures of preschool function in dire need of further empirical scrutiny. Concurrent and predictive validity of the MCDI and Battelle have been examined, along with the utility of the Stanford Binet, Fourth Edition. Presentations on these issues have included Ashmore, Saylor, Foster, and

Casto (1991) and Saylor (1992). A related manuscript about MCDI validity was just published in Journal of Pediatric Psychology (Shoemaker, Saylor & Eriksen, 1993). A manuscript on concurrence of the Binet, Battelle, and PLS has been submitted and reviewed twice. This year we will revise and resubmit. A manuscript on further MCDI studies will be submitted this year.

Conclusions

This chapter summarizes the research to date with a sample of children with very low birthweight and intraventricular hemorrhage who either received intervention beginning at three months adjusted age, or received intervention beginning at 12 months adjusted age. There developmental outcomes do not suggest substantial advantage to the earlier start, but the rich data set has begun to provide information that should help shed light on some of the complex factors influencing development in this understudied population.

This study was well designed and properly executed. It is clear from the analyses of the demographic data of the overall group that random assignment worked well and created groups which were comparable with respect to relevant characteristics of children and families. Statistically, the groups were balanced on all demographic and medical characteristics except the proportion of males in the groups. Mild differences on medical variables with potential clinical significance were dealt with using a Medical Severity Index as a covariate. In addition, the groups did not differ on any of the pretest child or family measures.

The results of the 12 month reassessment indicate that after nine months of sensorimotor intervention, the early intervention group demonstrated poorer developmental progress, though covarying the MSI minimized this difference. Family measures did not indicate any effects of the intervention. The results of the analyses of the second and third reassessment again indicated no significant differences between the groups. More recently, the 54- and 66-month reassessments confirm that both groups have made strong developmental progress, though the earlier start group does not show substantial advantage. In the most recent assessments, which are preliminary due to incomplete samples, the expected advantage for earlier intervention again is not apparent.

Studies in this data set and in combined South Carolina and Salt Lake city samples suggest that other factors, especially demographic factors, may have had a more substantial influence on developmental outcomes than the age of start. Maternal education and income, for example, seem to be stong predictors of developmental progress, along with perceived adequacy of resources. Since the South carolina sample is more diverse ethincially and socioeconomically than those employed in other studies, it will be important to examine these issues in more depth in the coming year. Issues of parenting stress and parent child interaction have also been examined, and further suggest the need for additional attention to the more subtle and complex processes by which these high risk, medically fragile youngsters overcome and their families overcome significant obstacles to maximize development.

COLUMBUS MEDICALLY FRAGILE PROJECT

Project #7

COMPARISON: Infants with Bronchopulmonary Dysplasia (BPD) or neurologic damage--Coordinated NICU transition services beginning prior to hospital discharge vs. traditional NICU referral and follow-up.

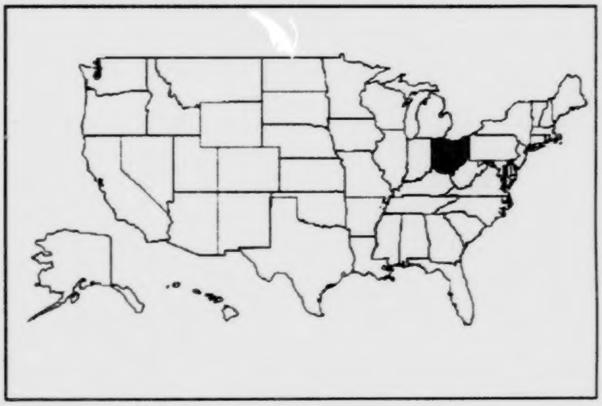
LOCAL CONTACT PERSON: Daniel Coury, Columbus Children's Hospital

EIRI COORDINATOR: Michael K. Godfrey

LOCATION: Columbus, Ohio

DATE OF REPORT: October 1, 1994

Rationale for the Study



There are multiple levels of direct and indirect influence on children's development (Lerner, 1992). Both organismic and environmental variables influence children and their families (Bronfenbrenner, 1979; Plomin, 1986; Sameroff & Chandler, 1975; Scarr, 1991; Waddington, 1957). Sameroff and Chandler (1975) postulate the environment serves to mediate the effects of adverse genetic conditions and influence subsequent developmental outcomes.

Lerner's (1984) developmental systems model and Bronfenbrenner's (1979) ecological model positions children and their families within larger networks. Bronfenbrenner views the environment as a set of nested, structural levels. Each structure is interdependent upon other structures both within and between levels. These interdependencies depict parents and children as influencing and being influenced by school, social networks, their family, and employment. Bronfenbrenner (1979) argues that the relationships between levels and systems can play as decisive a role in development as the events within a given level or system. Furthermore, each setting is embedded within a community, society and culture. This level of the theory has been recognized and laws such as P.L. 99-457, which encourages states to provide services to all infants and toddlers with disabilities, have been implemented. Time and history also influence each of these inter- and overlapping systems.

When children are born medically fragile, they are at risk for later medical distress and developmental delays. Families and their new infants need both immediate and long-term assistance. The Neonatal Intensive Care Unit (NICU) provides the short-term medical care children need, but is not meant to meet the infant's or family's long-term needs. When infants come home from the hospital, the support networks formed in the hospital may collapse, leaving families with additional concerns. Because of these post-discharge inadequacies the Columbus Medically Fragile (Columbus/MF) project was initiated to facilitate the family's ability to meet the infant's needs and impact the transition between the hospital and the community.

As the Bronfenbrenner model suggests, families of medically fragile infants vary along several major dimensions: infants affect the functioning of the family, which, in turn, influences the infant. Families and infants vary in the amount of influence exerted by the hospital, their response to society at large, and the community resources available. Following this model, the project at Columbus attempted to enhance each family's functioning, the infant's medical status, and the community's ability to meet the family's and infant's needs. The project also attempted to influence societal attitudes and practices regarding the care and development of medically fragile infants and their families. Figure 7.1 illustrates the model used to design services for children and families participating in this project.

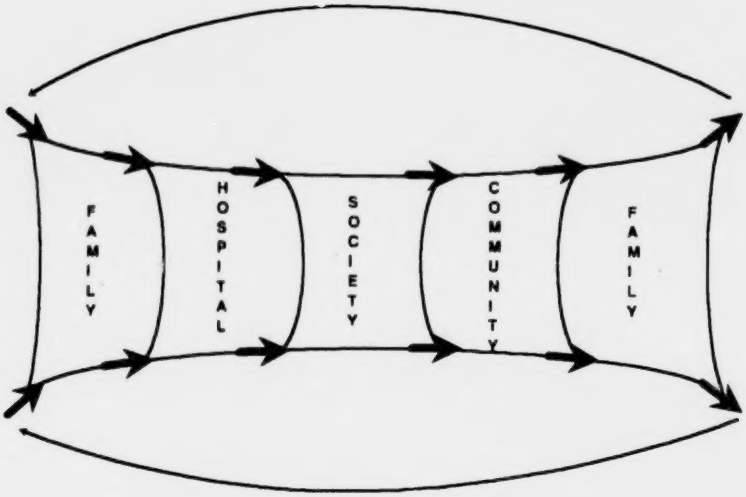


Figure 7.1: **Path of the Columbus/MF Project Model facilitating optimal family and infant functioning from the hospital to the community and home.**

The project was also guided by the theoretical models of adult education (Falvo, 1985; Knowles, 1980, 1984) and social support (House & Kahn, 1985; Madge & Marmot, 1987; Thorts, 1982; Veiel, 1985). Again, the goal was to provide services that aided the transition of families and infants to local professionals.

Medically fragile infants have an established risk for developmental delays due to serious long-term medical and nutrition problems. The lack of coordinated follow-up and intervention services in local areas, and little specialized training for local health, social service, and educational intervention personnel increase their risk status. There is a need to determine whether the developmental outcome of medically fragile infants and the functioning of their families can be improved through coordinated and comprehensive services designated to ease the transition from a hospital to a local community. The Columbus/MF program serves as a model for specialized care and support to the home and community following hospital discharge of the infant, rather than basing this support in the tertiary care hospital.

Review of Related Research

Approximately 7% of the children born in the U.S. were considered low birthweight in 1990 (U.S. Statistical Abstract, 1993). The projected developmental outcome for these infants warrants explicit efforts to design and experimentally test various interventions. Despite this need, a literature search revealed only nine studies that used an experimental design involving a comparison of intervention intensities of medically fragile or low birthweight infants ages 0-3. Table 7.1 presents these studies and summarizes the variables used to compare different groups, identify each study's quality, the duration of each program, a risk factor for children, and the effect size or findings of each study.

The comparisons in the reviewed studies have some components similar to aspects of the Columbus/MF study (i.e., home visits, developmental programs, physical therapy, and referrals to outside services). However, unlike any of the previously reviewed studies, the Columbus/MF study combined all of these components. To define each study's quality, a 5-point Likert-scale was used. The scale was based on evaluations of experimental design and internal validity. Six of the nine studies were rated good on study quality (The Infant Health and Development Program, 1990; Piper et al., 1986; Ramey & Campbell, 1987; Rauh et al., 1988; and Ross, 1984 and Scarr-Salapatec & Williams, 1973). Of the other three, one was rated fair (Dawson et al., 1990), and the rest were rated poor (Resnick et al., 1987; Slater, Nagui, Andres, & Haynes, 1987). The duration of the programs in the studies ranged from 3 months to 3 years.

The reviewed studies differ most from the present study in sample selection. The Columbus/MF project selected subjects based on neurologic or pulmonary difficulties. Piper et al. (1986) chose medically fragile subjects, while the Infant Health and Development Program (IHDP; 1990) and Rauh et al.'s (1988) sample excluded infants with severe medical difficulties. The rest of the studies most likely had

Table 7.1

Studies Which Examined Early Intervention for Low Birthweight or Medically Involved Infants

Reference	Comparison	Study Quality	Duration of Program	Child Risk Factor	Effect Size
Dawson, Robinson, Butterfield, van Doorninck, Gaensbauer, & Harmon (1990)	Weekly home visits and parent group meetings vs. weekly home visits vs. routine maternity and pediatric care	fair	16 months	Pregnant mothers expecting 1st or 2nd child	*
The Infant Health and Development Program (1990)	Home visits, child development center, parent group meetings, and pediatric follow-ups vs. pediatric follow-ups	good	36 months	Low birthweight, premature	.22
Piper, Kunos, Willis, Mazer, Ramsay, & Silver (1986)	Physical therapy treatment and parent-training program vs. regular neonatal follow-up program and referrals to physical therapists	good	9 months	At-risk for neurologic sequelae	+
Ramey & Campbell (1987)	Developmental preschool vs. no preschool control group	good	3 years	High-risk families	@
Raugh, Achenbach, Nurcombe, Howell, & Feti (1988)	Special NICU care and parent training vs. traditional NICU care for control group vs. no services for normal birthweight comparison group	good	3 months	Low birthweight, premature	.38
Resnick, Eyler, Nelson, Eitzman, Bucciarelli (1987)	Special care in NICU, parent training and home visits vs. traditional care in NICU and referrals to outside services	poor	2 years	Low birthweight	.39
Ross (1984)	Home visits vs. no services control group	good	1 year	NICU, low SES	.43
Scarr-Salapatec & Williams (1973)	Stimulation during nursery plus weekly home visits for the first year vs. standard pediatric care in the nursery	good	1 year	Low birthweight (<1800g), low SES	.60
Slater, Nagui, Andrew, & Haynes, (1987)	Interdisciplinary follow-up services at least once per year vs. not attending the follow-up services once each year	poor	3 years	Very low birthweight (<1500g)	1.06

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* Mother-infant interaction was better at 4 months in home-visited families than in routine care, especially with teenage and Hispanic mothers and other subgroups. (No data were given to calculate an ES.)

+ No statistically significant differences were found between groups.

@ Preschool intervention exerts an influence on intelligence and school success in the first 2 years of public school. (No data were given to calculate an ES.)

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some medically fragile subjects, but were combined with other subjects, either low birthweight or environmentally at risk (Dawson et al., 1990; Ramey & Campbell, 1987; Resnick et al., 1987; Ross, 1984; Scarr-Salapatec & Williams, 1973; Slater, Nagui, Andrew, and Haynes, 1987). The studies with low birthweight or environmentally at risk subjects showed moderate to large effects of the experimental interventions. Piper et al. (1986) found no significant differences between experimental and control groups with medically-fragile subjects. In a review of the early intervention literature, Dunst, Snyder, and Mankinen (1989), found that more severe children made smaller gains in development than at-risk or mildly disabled children. Since the current study involves medically fragile subjects similar to the sample in the Piper et al. 1986 study, effects similar to the Piper et al. (1986) study might also be expected in the present study.

Overview of Study

Two intensities of service to medically fragile infants and their families were investigated. The effects of a coordinated and comprehensive system of early intervention services initiated prior to discharge from the Neonatal Intensive Care Unit (NICU) were compared with the effects of services routinely provided by the hospital through medical check-ups and referrals following discharge. Infants in both the high and low-intensity intervention received NICU follow-up and referrals. This follow-up included regular assessments, pediatric check-ups and evaluations at the NICU clinic based at Columbus Children's Hospital. Referrals were made for all infants and their families to health and other service providers in their local communities. These services were provided to all NICU graduates of the hospital. In addition, the high-intensity group of infants received comprehensive, coordinated services from a transition team that helped facilitate their transition from a centralized source, Columbus Children's Hospital (CCH), to regional sources, agencies within local communities. The randomly assigned comparison group of children, the low-intensity group, received only the limited services previously available to CCH NICU graduates as described above and by Koops et al. (1984).

The children in each of the two groups were followed longitudinally. They and their families were assessed at two weeks following discharge from the hospital, at six months of age (corrected for prematurity through the 36-month assessment), 12, 18, 24, 36, and 48 months of age. The length of time the children were followed allowed an assessment of long-term intervention effects.

This report focuses on the comparison between the high and low-intensity groups for each assessment. Following the Methods section, the results and discussion section explores each reassessment. The Conclusions section finishes this chapter with results that are logically derived from the results.

Methods

This section outlines the experimental design and methods used in the Columbus/MF study. First, the method of subject recruitment will be described, including the selection procedures, group assignment, demographic characteristics, and subsequent attrition. Then the intervention programs will be described along with the methods used to validate the intervention procedures. To add perspective to the study, the cost of the alternative interventions will be explored. The methods section will conclude with the data collection procedures for each assessment.

Subjects

The Columbus/MF project enrolled 54 subjects between October 1, 1988 and March 12, 1990. These infants had medical complications and their parents agreed to participate in the study.

Recruitment. Medically fragile infants hospitalized in the Columbus Children's Hospital NICU were eligible to participate in the study if they were diagnosed with

Table 7.11

Comparison of Contextual Variables for High-Intensity and Low-Intensity Groups for the Columbus Medically Fragile Study

Variables	Low Intensity			High Intensity			p Value	ES[^]
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n		
12-Month Reassessment								
• Demographics								
% of children living with 2 parents	91		23	76		21	.18	-.53
Mothers hrs/week employment	9.0	(14.5)	23	11.9	(15.7)	21	.53	.20
Fathers hrs/week employment	28.0	(18.6)	21	34.4	(19.6)	19	.30	.34
Annual Family Income	$21,590	($15,739)	22	$28,619	($22,115)	21	.24	.45
% Siblings receiving sp. ed. services	17		23	5		21	.20	.52
• Family Variables								
Family Resources (FRS)[§]	116.6	(17.1)	23	126.9	(16.3)	20	.05	.60
Family Life Events (FILE)[•]	8.4	(4.5)	23	8.3	(5.3)	21	.95	.02
• % Receiving more than 5 hours week of child care	17		23	14		21	.78	.10
• % of Mothers employed outside of home	30.0		23	42.0		21	.40	-.30
• % Fathers Employed as Technical/ Managerial or above	10.0		21	35.0		20	.05	.78
24-Month Reassessment								
• Demographics								
% of children living with 2 parents	86		21	80		20	.64	.19
Mothers hrs/week employment	15.7	(18.7)	19	8.6	(14.1)	18	.20	-.38
Fathers hrs/week employment	31.6	(16.1)	18	42.1	(13.7)	15	.05	.65
Annual Family Income	$25,100	($16,357)	20	$33,111	($20,544)	18	.19	.49
% Siblings receiving sp. ed. services	29		14	18		17	.49	.32
• Family Variables								
Family Resources (FRS)[§]	111.3	(18.5)	23	126.1	(13.8)	21	.00	.80
Family Life Events (FILE)[•]	9.2	(6.0)	23	7.5	(3.6)	21	.27	-.28
• % Receiving more than 5 hours/ week of child care	27		22	19		21	.53	.23
• % of Mothers employed outside of home	50.0		20	38.0		21	.46	.27
• % Fathers employed as technical/ managerial or above	21.0		19	42.0		19	.17	.53

(table continues)

[^] $$ES = \frac{(\text{high intensity } \bar{x}) - (\text{low intensity } \bar{x})}{\text{low intensity SD}}$$ The ES indicates direction of difference, no value judgement is intended.

[§] Analyses for the FRS are based on raw scores indicating number of support on resources indicated by the family as being available. Higher scores and positive ES's are considered better.

[•] Analyses for the FILE are based on raw scores. Lower scores represent less stress and are considered better.

[%] Analyses for the Holmes-Rahe are based on raw scores. For both family stress and negative events lower scores represent less stress and are considered better.

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Table 7.11 (continued)

Comparison of Contextual Variables for High-Intensity and Low-Intensity Groups for the Columbus Medically Fragile Study

Variables	Low Intensity			High Intensity			p Value	ES[*]
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n		
36-Month Reassessment								
• Demographics								
% of children living with 2 parents	93		14	75		12	.22	.59
Annual Family Income	$27,846	($17,199)	13	$38,416	($23,560)	12	.21	.61
• Family Variables								
Family Resources (FRS)[a]	110.8	(20.9)	15	125.3	(10.2)	12	.04	.69
Major Life Events (Holmes & Rahe)%	180.9	(100.2)	15	137.3	(100.7)	12	.27	.44
Negative Events	27.1	(34.9)	15	28.8	(44.9)	12	.92	-.05
• % of Mothers employed outside home	60		14	40		12	.45	.33
• % Fathers employed as Technical/ managerial or above	20		13	30		11	.82	.12
48-Month Reassessment								
• Demographics								
% children living with 2 parents	80		15	56		16	.17	-.57
Annual Family Income	$28,833	($16,646)	15	$26,966	($22,135)	15	.80	-.11
• Family Variables								
Family Resources (FRS)[a]	119.5	(12.7)	15	119.1	(17.2)	16	.95	-.03
Major Life Events (Holmes & Rahe)%	80.2	(51.3)	15	177.3	(119.3)	16	.01	1.89
Negative Events	10.9	(22.7)	15	62.6	(76.1)	16	.02	2.27
• % Mothers employed outside home	50		13	20		16	.12	.68
• % Fathers employed as technical/ managerial or above	20		13	50		11	.12	.74

The family measures offered a perspective into family life. The changing circumstances within the families could also effect the outcome variables and subsequent child and family functioning. To measure these variables, families completed various questionnaires at each reassessment. Family variables that were judged to be subject to change and possibly affect later outcomes are also presented in Table 7.11. Measures included the Family Resource Scale (FRS), Family Inventory of Life Events (FILE), and the Holmes and Rahe Major Life Events (MLE).

The FILE was used for the 12 and 24 month reassessments as a measure of the changes occurring within the family. The life events that occurred for the two groups of families did not differ significantly at either the 12- or 24-month assessment. For the 36- and 48-month reassessments the MLE was used. The MLE differs from the FILE in several aspects. The items are weighted according to the amount of stress they cause in the participant's life. Thus the scores have a wider range and more variability. The MLE is divided into two subscales, the general score and the negative events score. The general score includes all the weights of events listed on the scale and the negative events score is the weighted total of the events classified as negative. These two scores are reported in Table 7.11 for the 36- and 48-month reassessments. Statistically significant differences emerged between the high- and low-intensity groups at the 48 month reassessment on both scales. The families in the high-intensity group reported more life events --both positive and negative-- than families in the low-intensity group. The difference at the 36-month reassessment suggested both groups were more similar than dissimilar. At both reassessments there was a large variation around the mean however, with very large ranges. Differences at the 48-month reassessment may be chance fluctuation of the sample assessed at that time.

There was also a statistically significant difference between groups on the FRS through the 36-month reassessment. The FRS indicates the number of resources the family perceives as available. The parents in the high-intensity group reported more available resources than the low-intensity group. As this is an outcome variable, as well as a contextual variable, the difference may be due to the intervention and reciprocally affect later outcomes. It is likely a real difference, however, in that each group remained relatively stable through the 36-month assessment with scores varying within a range of less than six points throughout the time. This finding is discussed in more detail in the family section of the results and discussion.

A comparison of the medical characteristics of all infants in the high-intensity and low-intensity intervention groups at the time infants were enrolled in the study (Table 7.12) indicated that the groups were similar on most medical measures. There was a statistically significant difference favoring the high-intensity group on oxygen dependence. The effect size approached half a standard deviation. Other relatively large effect sizes favoring the high-intensity group (indicating less medical intrusion) was found on respiratory and feeding status. The less-intensive group tended to be less dependent on technology, however, including a ventilator or pulmonary medications. By the time the infants were discharged from the hospital, the high-intensity group showed statistically significantly differences from the low-intensity group on sensory impairments only. This difference favored the high-intensity group. The results for the infant's 18-month reassessment indicated statistically significant differences on respiratory rate with the low-intensity infants having higher (more severe) scores. At the 36-month reassessment the overall score for medical severity was significantly different between the groups with the high-intensity infants scoring lower (less severe). By the 48-month assessment, however, these differences had disappeared. The medical severity index, a scale incorporating these medical indicators, was used as a covariate when appropriate in the analysis of outcomes presented in subsequent sections of this report.

Results and Discussion

The purpose of the Columbus Medically Fragile study was to compare the effectiveness of service levels to NICU graduates. A high-intensity group received comprehensive and coordinated early intervention services beginning prior to their discharge from an NICU facility. A low-intensity intervention group consisted of infants who received medical follow-up and typical referrals.

Table 7.11

Comparability of Groups on Medical Characteristics for the Columbus Medically Fragile Study

Variable	Low Intensity Group			High Intensity Group				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
Enrollment								
Gestational Age (weeks)	31.0	(4.7)	26	30.8	(5.2)	26	.85	-.04
Birthweight (grams)	1744.2	(861.2)	26	1616.1	(883.6)	26	.60	-.15
% diagnosed w/neurological impairment*	54.0		26	46.0		26	.59	.18
% diagnosed as high risk	15.0		26	19.0		26	.72	-.13
Medical Severity Index'								
Oxygen Dependence	1.6	(1.5)	26	1.0	(1.0)	26	.08	-.40
Respiratory Status	1.3	(1.2)	26	.8	(.9)	26	.15	-.42
Neurological Status	2.2	(1.7)	26	2.1	(1.7)	26	.87	-.06
Technology Dependence	.7	(1.1)	26	1.2	(1.6)	26	.17	.45
Feeding Status	2.5	(1.4)	26	1.9	(1.3)	26	.16	-.43
Sensory Impairment	1.1	(.9)	26	1.1	(1.1)	26	.89	.00
Total	15.3	(4.5)	26	14.2	(6.2)	26	.48	-.24
Initial Assessment (Discharge)								
Medical Severity Index'								
Length of Initial Hosp. Stay (days)	102.4	(75.4)	26	118.6	(91.0)	26	.49	.21
# Days on Ventilator	43.2	(42.2)	26	62.2	(74.6)	26	.26	.45
Days on Oxygen	81.5	(86.2)	26	93.1	(96.0)	26	.65	.13
Total Doses of Medication	7.7	(9.3)	26	6.0	(9.1)	26	.52	-.18
INFANIB Total Score'	58.4	(6.6)	26	58.5	(6.9)	26	.95	.02
Oxygen Dependence at Discharge+	1.1	(1.6)	26	.9	(1.3)	26	.57	-.13
Respiratory Status	1.1	(1.3)	26	.6	(1.1)	26	.15	-.38
Neurological Status	2.2	(1.7)	26	2.3	(1.6)	26	.87	-.06
Technology Dependence	.5	(1.1)	26	1.0	(1.7)	26	.26	-.45
Feeding Status	2.0	(1.6)	26	1.4	(1.1)	26	.12	-.38
Sensory Impairment	1.4	(1.4)	26	.8	(1.2)	26	.09	-.43
Total	15.5	(6.2)	26	13.3	(6.7)	26	.22	-.35
6-Month Reassessment								
Infanib Total Score'	53.6	(11.4)	21	82.2	(113.2)	20	.26	-2.5
12-Month Reassessment								
Days in Hospital Last Year	25.4	(39.9)	21	42.8	(92.4)	20	.44	-.43
Infanib Total Score'	63.1	(22.7)	23	59.3	(21.7)	20	.58	-.17
18-Month Reassessment								
Oxygen Dependence+	.6	(1.6)	22	.5	(1.4)	21	.88	.06
Respiratory Rate+	1.3	(1.7)	22	.6	(1.2)	21	.10	-.41
Technology Dependence+	.8	(1.3)	22	.8	(1.6)	21	.98	.00
Feeding Status+	1.4	(2.2)	22	.5	(1.5)	21	.11	-.41
Rehospitalization Days	.7	(1.2)	22	.6	(1.2)	21	.77	-.08
24-Month Reassessment								
Oxygen Dependence+	.4	(1.3)	20	.3	(1.1)	20	.69	-.08
Respiratory Rate+	.2	(.7)	20	.2	(.7)	20	1.00	.00
Technology Dependence+	.8	(1.4)	20	.4	(1.2)	20	.33	-.29
Feeding Status+	1.2	(2.1)	20	.5	(1.5)	20	.27	-.33
Hospitalization days	8.9	(21.9)	23	5.1	(7.2)	21	.46	-.17
36-Month Reassessment								
Health Index Total	3.7	(1.8)	15	2.1	(1.7)	12	.02	-.89
Hospitalization days	4.5	(7.2)	15	1.5	(3.1)	12	.19	-.42
48-Month Reassessment								
Health Index Total	2.5	(1.5)	15	2.5	(1.9)	13	.99	.00
Hospitalization Days	10.5	(32.2)	14	.3	(.6)	16	.22	.32

* To be included in the study, infants were diagnosed with either BPD or neurological impairment. Those infants not diagnosed with neurological impairment were included because of BPD.

+ Scores ranged from 1 to 5 with high scores considered more severe.

' High scores are considered worse.

' The INFANIB analysis was conducted using raw scores. A higher score indicates greater neurological maturity.

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Comparison of Groups on Initial Measures

As Table 7.2 showed, the families did not differ according to their by group assignment on most demographic variables. The father's years of education was statistically significant, but in reality was a small practical difference. Nevertheless, the variable was considered as a possible covariate in subsequent analyses.

Similar to the demographic variables, there were no statistically significant differences between the high- and low-intensity groups on the initial two-week post-discharge assessments. On the initial child development measure, the BDI, the children were functioning (on average) at the lower end of the scale. As Table 7.13 indicates, children scored at or below the 38th percentile across the subscales of the BDI. There were no significant differences between the two groups on the developmental measure.

Family measures collected at the time of the two-week post discharge included the Parenting Stress Index (PSI), Family Adaptability and Cohesion Evaluation Scales (FACES), the Family Resource Scale (FRS), Family Support Scale (FSS) and the Family Inventory of Life Events (FILE). Although there were significant differences between the high- and low-intensity groups on the FRS and FSS at the initial post-discharge assessment, they could not be included as initial pre-intervention assessments. The PSI, FACES, and FILE did not show a significant difference between groups, but likewise, they could not be included as initial preintervention assessments either. The family measures are suspect as initial assessments because of the intervention received between enrollment and the infant's discharge from the hospital. Infants were hospitalized for up to 6 months prior to discharge from the NICU. This meant that many families in the more-intensive intervention received a significant number of visits prior to the initial family assessment at two weeks following discharge from the NICU. During this period, services focused on helping the family prepare

Table 7.13

Comparability on Assessment Measures for the Low-Intensity and High-Intensity Groups at the Columbus Medically Fragile Project

	Low-Intensity Group				High- Intensity Group					
Variable	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	p Value	ES
Adjusted age at assessment in months	1.8	(2.2)		26	2.1	(3.3)		26	.68	.14
Battelle Developmental Inventory (BDI)										
Personal/Social	6.0	(4.1)	10	26	7.9	(6.6)	12	26	.21	.46
Adaptive	3.8	(2.8)	10	26	4.5	(3.9)	18	26	.47	.25
Motor	4.9	(4.4)	10	26	5.0	(4.7)	10	26	.98	.02
Fine	2.2	(1.6)	34	26	2.5	(1.9)	38	26	.48	.19
Gross	2.7	(3.3)	8	26	2.3	(3.1)	6	26	.67	-.12
Communication	4.7	(2.1)	22	26	4.9	(2.6)	22	26	.82	.10
Receptive	3.8	(1.5)	38	26	4.1	(2.0)	38	26	.48	.20
Expressive	1.0	(1.3)	18	26	.8	(1.3)	18	26	.60	-.15
Cognitive	3.4	(2.9)	34	26	3.0	(3.5)	34	26	.61	-.14
TOTAL	22.9	(14.5)	6	26	25.3	(20.0)	10	26	.61	.17
Infant International Neurological Battery	58.4	(6.6)		26	58.5	(6.9)		26	.95	.02
Parenting Stress Index (PSI)										
Total	238.5	(47.4)	70	25	230.5	(45.4)	63	25	.55	.17
Child-Related	109.8	(21.8)	78	25	113.5	(25.1)	85	25	.58	-.17
Other Related	128.7	(27.6)	65	25	117.0	(26.5)	44	25	.13	.42
Family Adaptation and Cohesion Evaluation Scales (FACES III)										
Adaptability	21.8	(5.6)		26	24.7	(7.4)		26	.12	.52
Cohesion	37.8	(6.2)		26	39.0	(8.3)		26	.56	.19
Family Resource Scale (FRS)	116.8	(18.4)	48	26	125.3	(17.4)	63	26	.09	.46
Family Support Scale (FSS)	25.8	(9.6)	45	26	30.8	(10.4)	63	26	.08	.52
Family Inventory of Life Events (FILE)	11.4	(5.2)	34	26	11.8	(7.6)	29	26	.83	-.08

for the transition of the infant to the home. Transition team members believed there was a high probability that these measures of family functioning could have been influenced by the services provided. These measures while informative, are inappropriate pre-intervention measures. They are presented in Table 7.13 for information purposes only. The measures are also presented later with the outcome measures.

While families in the more intensive intervention received significant quantities of intervention from the transition team between the time of enrollment and the two-week post-discharge assessment, the services were not focused on child development activities. Consequently, measures of child functioning collected at the two-week post-discharge assessment are not analyzed as outcomes, but as initial measures.

Covariate Selection

Analysis of covariance (ANCOVA) procedures were used to evaluate differences between groups on measures of child and family functioning following intensive, coordinated early intervention transition services to one group of infants and less intensive routine medical follow-up for the other group. Analysis of covariance procedures were used for two reasons: (a) to increase the statistical power of the study by reducing error variance; and (b) to adjust for any pretreatment differences which were present between the groups. In either application, the degree to which analysis of covariance is useful depends on the correlation between the covariate(s) selected and the outcome variable for which analyses are being done. However, since one degree of freedom is lost for each covariate used, it is generally best to use a limited number of covariates in any given analysis. All pretest and demographic variables were considered as potential covariates. The final selection of covariates depended on a judgment of which variable or set of variables could be used to maximize the correlation or multiple correlation with the outcome variable in question and still include those demographic or initial assessment variables for which there were the largest pretreatment differences. For example, age at the initial assessment and level of severity at discharge were used as covariates for the first reassessment's Bayley Mental Developmental Index scores. The combination of these variables reduced the amount of unexplained variance in the first reassessment Bayley scores better than other combination of initial assessment or demographic variables.

Although sample sizes for this study are as large or larger than previous early intervention studies with these types of children, the statistical power of the analysis is still a concern. By setting the alpha level for all tests of statistical significance at $p \leq .10$, and by using analysis of covariance procedures, the statistical power of the analyses was substantially increased. According to Hopkins (1973) and Cohen (1977), in those cases where a covariate or set of covariates could be found which correlated with the dependent variable in question (which was almost always the case in these analyses), and with alpha set at $p \leq .10$, the statistical power was approximately 94% for finding moderate sized differences (defined by Cohen as differences of a half a standard deviation).

Effects of High Intensity vs. Low Intensity Intervention on Measures of Child Functioning

Measures of child functioning across reassessments showed few statistically significant differences between the high- and low-intensity groups (see Table 7.14). The average effect size across all reassessments equated to -.02, again revealing little if any effect due to the intervention or group assignment. Despite the lack of statistically significant results, individual reassessments warrant further investigation and explanation.

At the 6-month reassessment (age corrected for prematurity) infants were administered the Bayley Scales of Infant Development (Bayley) and the Infant International Neurological Battery (INFANIB). Neither assessment showed significant differences between groups after preassessment variables were used as covariates. The statistical power was deemed appropriate as the covariates both correlated with the dependent variables and were significant in multiple regressions across each of the reassessments the measures were used. The covariates, where more than one was chosen, were also minimally correlated with each other thereby minimizing colinearity. The mental processing subscale of the Bayley, while failing to reach statistical significance, had an effect size of .53. This slightly over one-half standard deviation suggests an immediate cognitive benefit to the high-intensity

Table 7.14

Summary of Reassessment ANCOVAs on Measures of Child Functioning for Alternative Intervention Groups in the Columbus Medically Fragile Study

	Covariate◆	Low Intensity Group				High Intensity Group				ANCOVA F	p Value	ES
		$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n			
6-MONTH REASSESSMENT												
Adjusted Age in Months		5.6	(.7)		21	5.6	(.6)		20	.01	.92	.00
INFANIB· Total (range:20 to 100)	1,8	53.6	(11.4)	55.6	21	56.9	(10.7)	54.9	20	.04	.84	-.06
Bayley·												
Motor	9,10	69.4	(25.1)	73.4	23	81.2	(23.4)	77.3	22	.46	.50	.26
Mental	1	73.9	(21.3)	78.5	23	91.0	(33.1)	86.3	22	1.09	.30	.53
Carey Infant Temperament Scale												
Distractibility	9,11	249.1	(39.5)	240.4	17	243.5	(76.0)	252.2	19	.61	.44	-.14
Approach/Withdrawal	12	265.2	(78.1)	268.0	17	257.5	(55.1)	254.7	19	.40	.53	-.10
Adaptability	12,13	266.3	(75.7)	256.2	16	252.4	(46.9)	262.5	18	.18	.68	-.18
Intensity	14	326.6	(57.9)	232.0	17	344.5	(41.6)	348.1	19	2.30	.14	.31
Mood	15	320.4	(58.2)	318.4)	17	326.9	(95.5)	328.9	19	.19	.67	.11
Persistence	16	335.8	(66.0)	339.5	17	333.8	(77.2)	330.1	19	.16	.70	-.03
Activity		395.2	(56.1)	395.2	17	396.3	(55.6)	396.3	19	.00	.95	.02
Rhythmicity	9	1.4	(1.5)	308.0	17	.9	(1.2)	296.5	19	.09	.76	-.33
Threshold	14,17	402.6	(65.6)	399.7	17	403.8	(69.0)	406.8	19	.13	.73	.02
12-MONTH REASSESSMENT												
Adjusted Age in Months		12.1	(.8)		23	12.1	(.7)		19	.03	.87	.00
Battelle Developmental Inventory·												
Personal/Social	1[&]	26.6	(10.4)	27.3	23	31.6	(7.3)	30.8	21	1.70	.20	.34
Adaptive Behavior	1	19.7	(11.1)	21.2	23	23.0	(10.1)	21.6	21	.01	.91	.04
Motor	1	25.9	(14.9)	28.2	23	27.9	(14.4)	25.6	20	.49	.49	-.17
Communication	1	16.0	(7.7)	16.9	23	18.8	(6.6)	17.8	20	.18	.68	.12
Cognitive	1	14.0	(7.2)	14.9	23	14.5	(5.9)	13.6	20	.47	.50	-.18
TOTAL	1	102.6	(49.1)	109.3	23	114.8	(40.9)	108.1	20	.01	.92	-.02
General Health		1.6	(.7)	1.7	17	1.7	(.5)	1.6	21	.26	.62	-.14
Infanib· Total (range 20 to 100)	1	63.1	(22.7)	65.0	23	59.3	(21.7)	57.4	20	1.30	.26	-.34
18-MONTH REASSESSMENT												
Adjusted Age in Months		20.1	(1.3)		22	20.1	(1.5)		21	.00	.99	.00
Vineland·												
Communication	2	78.9	(10.6)	78.7	22	80.2	(11.5)	80.4	21	.37	.55	.19
Daily living skills	9,10	77.3	(14.3)	78.9	22	78.9	(14.4)	77.3	21	.17	.68	-.11
Social	2	83.2	(15.9)	82.8	22	89.5	(12.0)	89.8	21	3.73	.06	.40
Bayley·												
Motor	1	69.5	(21.3)	71.8	22	67.3	(20.5)	65.0	21	1.28	.27	-.23
Mental	1,4	71.6	(23.9)	74.4	22	73.7	(23.6)	70.9	21	.28	.60	-.04

· INFANIB and BDI statistical analyses were conducted using raw scores for each of the scales.

· Effect Size (ES) is defined here as the difference between the groups (High Intensity minus Low Intensity) on the $\bar{x}$ scores, divided by the standard deviation of the Low-Intensity Intervention Group (see Cohen, 1977; Glass, 1976; Tallmadge, 1977 for a more general discussion of the concept of Effect Size). A positive ES difference indicates a variable which is more favorable for the high-intensity group, while a negative ES is more favorable for low-intensity group subjects.

· Bayley analysis was conducted using standard scores.

[&] Analysis is based on scores that range from 6 to 24.

◆ Child's Medical Severity Index score correlated highly with the outcome measures for the 12 and 24 month measures, but their neurological status correlated higher at the 36 and 48 month assessments.

Table 7.14 (continued)

Summary of Posttest ANCOVAs on Measures of Child Functioning for Alternative Intervention Groups for the Columbus Medically Fragile Study

		Low Intensity Group				High Intensity Group						
	Covariate[◆]	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES
24-MONTH REASSESSMENT												
Adjusted Age at Reassessment in Months		24.7	(1.5)		23	25.3	(2.3)		21	.81	.37	.40
Battelle Developmental Inventory[+] (BDI)												
Personal/Social	1[♠]	55.7	(24.3)	58.2	23	58.6	(21.0)	56.1	21	.11	.74	-.09
Adaptive Behavior	1	36.7	(17.9)	39.1	23	39.9	(15.6)	37.5	21	.14	.71	-.09
Motor	1,3	53.8	(30.4)	59.0	22	53.2	(26.2)	48.0	21	2.27	.14	-.36
Communication	1	27.8	(10.5)	29.0	23	31.9	(7.0)	30.8	21	.54	.47	.17
Cognitive	1,5	20.6	(8.4)	21.2	23	21.7	(7.7)	21.1	21	.00	.99	-.01
TOTAL	1	194.9	(87.3)	205.0	23	205.3	(71.5)	195.2	21	.20	.65	-.11
General Health		1.7	(.7)	1.78	23	2.2	(.7)	2.2	21	4.77	.04	.53
36-MONTH REASSESSMENT												
Adjusted Age at Reassessment in Months		38.4	(2.5)		15	38.4	(2.4)		12	.00	.98	.00
Battelle Developmental Inventory[+] (BDI)												
Personal/Social	2[♠]	88.3	(35.0)	92.2	15	90.0	(30.0)	86.1	12	.47	.50	-.17
Adaptive Behavior	2	54.3	(23.0)	56.8	15	52.8	(20.0)	50.2	12	1.19	.29	-.29
Motor	2,4	66.0	(33.8)	70.2	14	71.1	(32.0)	66.9	12	.12	.74	-.10
Communication	2	41.5	(17.3)	43.4	15	45.6	(16.0)	43.7	12	.01	.94	.01
Cognitive	2,4	29.4	(1.8)	31.0	14	31.8	(1.2)	30.1	12	.07	.79	-.05
TOTAL	2,12	274.2	(116.9)	300.6	14	291.2	(105.0)	264.8	12	1.47	.24	-.31
General Health	1	1.8	(.6)	1.9	15	1.9	(.5)	1.8	12	.54	.47	-.17
48-MONTH REASSESSMENT												
Chronological Age at Reassessment in Months		51.7	(2.1)		15	50.7	(2.9)		16	1.2	.28	-.48
Battelle Developmental Inventory[+] (BDI)												
Personal/Social	2[♠]	104.5	(46.1)	107.0	15	100.1	(43.7)	97.7	16	.49	.49	-.20
Adaptive Behavior	2	62.0	(30.0)	63.6	15	59.8	(26.7)	58.2	16	.43	.52	-.18
Motor	2	79.2	(40.6)	81.1	15	73.3	(37.1)	71.3	16	.67	.42	-.24
Communication	2	50.4	(26.9)	51.7	15	53.7	(24.9)	52.4	16	.01	.93	.03
Cognitive	2,12	37.8	(22.9)	38.7	14	40.1	(20.4)	39.2	16	.00	.95	.02
TOTAL	2	336.5	(159.3)	344.7	15	326.4	(145.5)	318.1	16	.35	.56	-.17
Parent Protection Scale												
TOTAL		37.7	(7.1)	37.7	3	36.1	(5.9)	36.1	9	.14	.71	-.23
Child Vulnerability TOTAL		8.3	(5.5)	8.3	3	8.7	(4.6)	8.7	7	.01	.91	.07
Perceived Competence and Social Acceptance[e]												
Cognitive Competence		8.0	(10.3)	8.0	15	6.5	(10.2)	6.5	13	.16	.70	-.15
Peer Acceptance		7.2	(9.5)	7.2	15	6.8	(10.7)	6.8	13	.01	.91	-.04
Peer Competence		7.8	(10.0)	7.8	15	6.0	(9.8)	6.0	13	.23	.64	-.18
Maternal Acceptance		8.0	(10.3)	8.0	15	6.8	(10.7)	6.8	13	.10	.76	-.12
General Health		1.8	(.7)	1.8	14	1.9	(.3)	1.9	16	.21	.65	.14

(see previous page for notes)

group, although the benefit apparently wore off before the Bayley was used again at the 18-month reassessment.

Mothers completed the Carey Infant Temperament Scale (ITQ) at the 6-month reassessment. This measure includes nine subscales that, when evaluated as a whole, aid in the classification of infants into one of several diagnostic temperament clusters. Although temperament is hypothesized to be an innate characteristic, research has shown that the current instrument measures the mother's perception of her infant and not the infant (Vaughn, Taraldson, Crichton, & Egeland, 1981). Because mothers' perceptions are relative and can be changed, the ITQ is included as an outcome measure. The high-intensity intervention should have had a positive influence on mother's perception of their infants and given them additional power in dealing with their six-month-old infant. The p-values for the nine scales failed to reach significance between the two groups, and the effect sizes were not large enough to warrant further investigation.

However the diagnostic clusters of the ITQ did show interesting differences. Analysis of the differences must be subjective because of the lack of statistical procedures for this form of data with this many categories and subjects. Traditional parametric and non-parametric tests of significance are inappropriate. Parametric tests are inappropriate because of the nominal nature of the data. Non-parametric tests yield spurious results because of the low expected frequency in each cell. Visual examination of Figures 7.2 and 7.3 show how the two groups differed. The categorical mode for the low-intensity group placed the infants in the difficult category. Mothers in this group perceived their infants to be arrhythmic, likely to withdraw from interactions, slow to adapt to routines, intense, and show a generally negative mood when rated against other infants. Only 16% of mothers in the high-intensity group rated their infants as difficult. They generally perceived their infants as "intermediate high." This category is comparable to the difficult category, though the ratings are not as extreme. Twenty-six percent of the high-

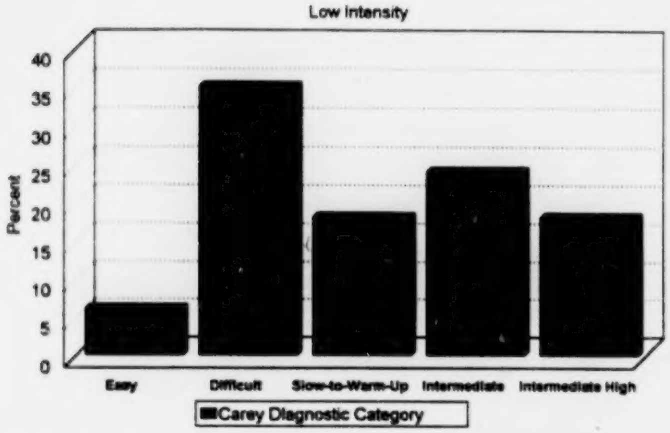

Figure 2. Bar Chart showing the percentage of infants in each category of the Infant Temperament Questionnaire for the Columbus Medically Fragile Low-Intensity group.

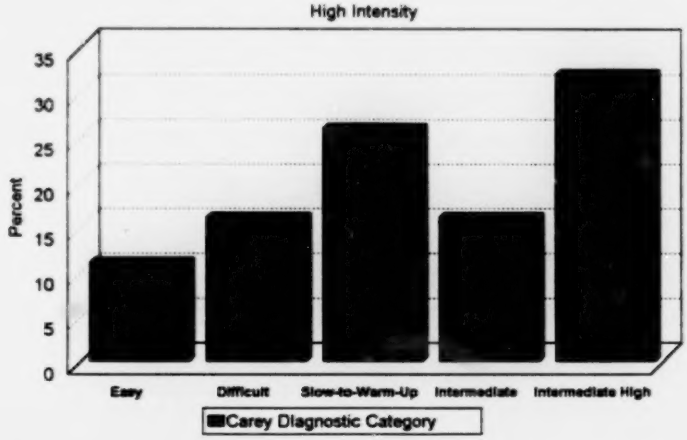

Figure 3. Bar Chart showing the percentage of infants in each category of the Infant Temperament Questionnaire for the Columbus Medically Fragile High-Intensity group.

intensity mothers perceived their infants as slow-to-warm-up. This compared to 24% of the mothers in the low-intensity group who rated their infants' intermediate low--a category reserved for infants whose temperament is perceived as easier than intermediate high but much more difficult than easy. The easy category was the one that was used the least, only 6% in the low-intensity group compared to 11% in the high-intensity group.

The Vineland Adaptive Behavior Scales were administered at the 18-month reassessment. While the communication and daily living skills scales were not statistically significantly different, the social scale did show a statistically significant difference. The children in the high-intensity groups were seen as being more social. This is contrary to the personal/social domains of the BDI assessments administered six months before and after this assessment, but is consistent with the different ITQ diagnostic categories of difficult and intermediate high. One possible solution may be that the BDI personal/social domain is not as sensitive to social skills as the Vineland for infants.

The BDI was administered at the 12, 24, 36, and 48 month assessments. Similar to the initial assessment, no significant differences emerged for any subscale or for the total score at any reassessment. The effect sizes were likewise generally negligible. Interestingly, while the effect sizes were minimal, the 24, 36 and 48-month reassessments generally showed negative effect sizes while the assessment at the 12-month reassessment showed positive effect sizes. The samples appear to be different at the 36 and 48-month assessments also. Due to the different samples at these two reassessments (because of non-assessment), the variables that correlated with the BDI for covariate selection changed. For the 12 and 24-month reassessments, scores on the Medical Severity Index from the enrollment were generally seen as an appropriate covariate. The infant's neurological status at enrollment appeared to be a better choice for the 36 and 48-month reassessments, however.

Analysis of the BDI total scores at each reassessment placed the sample, as a group, below the first percentile. Adding one standard deviation (as defined by the group assignment) to the mean for each group placed children scoring that highly in increasingly higher percentiles as they matured. For example, at the 12-month reassessment, those scoring one standard deviation higher than the mean were in the forth percentile. Children scoring one standard deviation above the mean of the group at the 48-month reassessment placed in the thirty-second percentile. This upper score gave those children an age equivalent score of 50 months (the actual age for the group as a whole was 51.2 months). Age equivalent scores for children who obtained the group mean score were only 29 months, 22 months below their actual age. While the means remained low relative to the normative sample, children who scored in the upper range of the group showed gains relative to the normative sample.

Starting at the 12-month reassessment the parents were asked to rate their child's health. The scale asked for the parents' perceptions of their child's health compared to the health of other children. The three-point scale asked if their child was less healthy, about the same, or more healthy than other children. At the 24-month reassessment parents in the high-intensity group had an average rating for their children as "about the same as other children." This was a statistically significant difference from the low-intensity group who averaged slightly below "about the same as other children". The difference faded in the following years, possibly because of a chance finding, but more likely because of the different samples. For the 36 and 48-month assessments parents in the low-intensity group rated their children's health as increasing while parents in the high-intensity group fluctuated, but never dropped much below the middle rating.

The Preschool Pictorial Perceived Competence and Social Acceptance Scale was administered to children at the 48-month reassessment. The scale did not show any statistically significant differences between the groups. Examination of the scores showed that most children were scoring at the lower end of the scale, suggesting it may be inappropriate for these children. Anecdotal information from the assessment administrators confirmed that very few children understood what they were supposed to do for the assessment. For those who did respond, most appeared to respond in a random fashion.

Across reassessments and across time, few differences emerged between the children in the high- and low-intensity groups. Outcome measures for the children did not show any consistent group differences. Despite the lack of statistically significant differences, interesting knowledge about the infants was gained. Children in the low-intensity group were more likely to be classified as difficult on the ITQ than children in the high-intensity group. It is conceivable that the intervention made a difference in the mother's perception of her infant, thereby theoretically increasing their positive interactions or increasing their optimistic outlook. Children scoring on the upper end (relative to this sample) of the BDI appeared to have made gains relative to their peers. Children who scored at or below the mean stayed behind their same age peers. This observation warrants further attention.

The lack of differences on child measures may also say little about the intervention. While it appears that increased services did not directly impact child functioning as measured by these instruments, it did not hurt their development either. If the intervention had an affect in other areas -such as a decreased probability of needing further early intervention services- the increase in early services may have been worth the cost. From a parents perspective, if they think it will help, and it is unlikely to hinder development, let them choose if the intervention is worth the extra time and effort. Chances are, they know what will make a difference more than a stranger who interacts with the family for a very brief period. These results call for a more individual approach to early intervention, not a program for the masses where one amount is the best for everybody. An intervention of this sort may increase the parent's perception of their infant and have an indirect impact as the children mature.

Effects of Alternative Forms of Intervention on Measures of Family Functioning

Whether or not the intervention had an effect on the families' functioning was a primary importance to the current study. Measures of family functioning were gathered at each reassessment. Consistent measures included the Parenting Stress Index (PSI), the Family Support Scale (FSS), and the Family Resource Scale (FRS).

Other measures included the Family Adaptation and Cohesion Evaluation Scales (FACES) and the Parent Self-Awareness Scale (PSAS).

The FRS was used as a measure of the resources available to the family. These resources included various forms of general resources, physical resources, time availability, and external support. As a contextual variable, the FRS showed statistically significant differences through the 36 month reassessment (refer to Table 7.11). Resources are typically considered outside a researchers control for this form of early intervention, but a goal of the intervention was to aid families in finding appropriate services for their infants, thereby adding to the family's resources. As an outcome variable, using analysis of covariance techniques, the FRS showed statistically significant differences between the high- and low-intensity groups at the 12 and 36-month assessments. Although not statistically significant at the initial assessment or the 6, 18, or 24-month assessment, the results favored the high-intensity group through the 36-month assessment. The 48-month assessment, however, provided results that were equivalent between the groups (see Table 7.15).

To further analyze the results, it was hypothesized that the intervention would most likely affect the time availability and external supports scale of the FRS. The external support scale was statistically significant between the groups for only the 36-month reassessment. The results again favor the high-intensity group suggesting that they perceived more external supports at that time. However, this difference is not statistically significant at the other reassessments and may be a chance finding. Time availability, on the other hand, showed significant differences at the 12, 24, and 36 month assessments. At each reassessment the families in the high-intensity group perceived they had more time availability than their low-intensity counterparts.

The PSI was administered at the initial assessment, at the 12, 24, 36 and 48-month reassessments. The initial assessment is included with these analyses because of substantial amounts of intervention that occurred before the initial assessment.

Table 7.15

Summary of ANCOVAs on Measures of Family Functioning for Alternative Intervention Groups for the Columbus Medically Fragile Study

		Low Intensity Group				High Intensity Group						
	Covariate◆	$\bar{X}$	(SD)	Adj.$\bar{X}$	n	$\bar{X}$	(SD)	Adj.$\bar{X}$	n	ANCOVA F	P Value	ES
INITIAL ASSESSMENT												
Parenting Stress Index♣ (PSI)												
Child Related	1	109.8	(21.8)	109.3	25	113.5	(25.1)	113.9	25	.51	.48	-.21
Other Related	2	128.7	(27.6)	126.2	25	117.0	(26.5)	119.5	25	.80	.38	.24
TOTAL	2	238.5	(47.4)	234.5	25	230.5	(45.4)	234.5	25	.00	.99	.00
Family Adaptation and Cohesion· Evaluation Scales (FACES)												
Adaptation	3	21.8	(5.6)	21.9	26	24.7	(7.4)	24.5	26	2.20	.14	.46
Cohesion	2,4	37.7	(6.3)	38.5	25	39.0	(8.3)	38.2	26	.04	.85	-.05
Family Support Scale (FSS)	5	25.8	(9.6)	25.9	26	30.8	(10.4)	30.6	26	3.10	.09	.49
Family Resource Scale (FRS)	2,4	116.0	(18.3)	117.4	25	125.3	(17.4)	123.9	26	1.90	.17	.36
6 MONTH REASSESSMENT												
Family Support Scale	1,2	29.0	(12.4)	29.3	21	32.1	(8.4)	31.8	20	.65	.42	.20
Family Resource Scale	3,4	120.3	(12.5)	122.1	21	128.6	(13.8)	126.8	20	2.21	.15	.38
12-MONTH REASSESSMENT												
Parenting Stress Index♣ (PSI)												
Child Related	14	111.1	(19.3)	110.3	22	105.3	(22.9)	106.1	21	.46	.50	.22
Other Related	12,13	132.8	(23.8)	128.0	22	124.8	(31.2)	129.6	21	.06	.81	-.07
TOTAL	13,14	244.0	(38.9)	239.5	22	230.1	(51.2)	234.6	21	.16	.69	.13
Family Adaptation and Cohesion· Evaluation Scales (FACES)												
Adaptation	9,10	21.9	(7.0)	22.0	22	23.3	(8.5)	23.3	19	.31	.58	.13
Cohesion	17	37.3	(6.6)	38.0	23	35.5	(9.5)	34.9	21	1.80	.19	-.36
Family Support Scale (FSS)	4	25.7	(10.9)	24.9	23	29.0	(10.0)	29.7	20	2.44	.13	.34
Family Resource Scale (FRS)	7,2,5	116.5	(17.5)	116.9	22	126.9	(16.3)	126.4	20	4.00	.05	.54
External Support	2	23.3	(4.3)	23.5	23	24.4	(4.5)	24.2	20	.34	.56	.16
Time Availability	4,7	37.9	(10.7)	37.6	23	43.6	(11.1)	43.9	20	4.20	.05	.59

Effect Size (ES) is defined here as the difference between the groups (High Intensity minus Low Intensity) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation of the Less Intensive Intervention Group (see Cohen, 1977; Glass, 1976; Tallmadge, 1977 for a more general discussion of the concept of Effect Size). For the PSI and FILE, the numerator for the ES is calculated as: Less Intensive - More Intensive, as lower scores are preferred. A positive ES difference indicates a variable which is more favorable for the high-intensity group, while a negative ES is more favorable for low-intensity group subjects.

♣ Low scores indicate less stress.

· Scores for each subscale of the FACES are derived based on linear scoring where high scores are preferred.

◆ 1 = Hours employed per week--mother; 2 = highest completed year of education--mother; 3 = mother's occupational SES category; 4 = Sensory impairment at enrollment; 5 = Total yearly income for household; 6 = Number of days on ventilator; 7 = Family Index of Life Events and Changes (FILE); 8 = Gestational age (weeks); 9 = Dad's age; 10 = No. days of oxygen dependency; 11 = Age at diagnosis; 12 = Parenting Stress Index parent related subscale at assessment; 13 = Family Resource Scale Total Score; 14 = Parenting Stress Index Total Score; 15 = Parenting Stress Index Child Related Subscale at Assessment; 16 = Respiratory Status; 17 = Cohesion, 18 = Father's Occupational Status.

moderate to severe bronchopulmonary dysplasia (BPD) and had a need for oxygen therapy and/or two or more pulmonary medications upon hospital discharge. Infants with neurologic conditions (e.g., severe [Grade IV] perinatal intraventricular hemorrhage, hydrocephalus, microcephaly), requiring specialized equipment (e.g., feeding pumps, suction, and/or aerosol equipment), were also eligible.

Eligible infants were identified for inclusion in the study when their weight reached 1500 g (approximately one month before discharge). At that time, parents were contacted by the project's clinical nurse specialist. The nurse explained to the parents the nature of the study, requested their participation, and, if parents were willing, obtained informed consent. If parents decided not to participate in the study, their infant received routine medical and developmental follow-up through the Neonatal Follow-up Clinic, and, if necessary, was referred to local agencies for the typically limited health, occupational therapy, physical therapy, and early intervention services.

__Assignment to groups__. Following enrollment, and after being stratified by their primary diagnosis of BPD or neurological damage, the infants were randomly assigned to either a high- or low-intensity intervention group. The BPD and neurological groups were each further stratified into groups of more or less severe illness based on a medical severity index developed by the hospital staff.

The severity index allowed a physician to rate the infants on a scale of 0-5, with 5 being the most severe or abnormal rating. The severity index included nine variables: (1) the infant's degree of technology dependence, (2) oxygen dependence, (3) respiratory status, (4) age at discharge, (5) neurologic status, (6) ultrasound/CT findings, (7) head circumference, (8) feeding status, and (9) sensory impairment. These variables were theoretically linked to medical outcome. A total severity score was obtained from the nine variables. The total score ranged from 3 to 45 points. Infants receiving a score below 19 were determined to be "low risk;" those receiving a score of 19 and above were considered "high risk." Following both stratification procedures, group assignments were randomly made by the EIRI site coordinator, who was unknown to the infants and their families. Parents were informed of their child's group assignment as soon as they were enrolled.

Demographic characteristics. Information was gathered by questionnaires regarding family income, ethnic background, parent occupation, number of siblings, and primary caretaking responsibilities of the participating families. Infants averaged 2.0 months old (age corrected for prematurity) at the 2-week post-discharge assessment. The mean chronological age was 4 months. Age did not differ by a statistically significant amount between groups. There were more females than males in both groups (75% overall) and the infants generally had either one or two siblings at their birth.

Fathers were typically three years older than their infants' mothers who were 26.5 years old. At the time of the two-week assessment, most families had two parents, 21% belonged to single-parent households. Most of the parents had graduated from high school but had not attended much college. Across the sample, parents' education ranged from the eighth grade to a masters degree with most graduating from high school. Sixty-seven percent of the mothers were _not_ employed outside their home. Almost twice as many mothers in the high-intensity group were employed outside their home when compared to the low-intensity group (this difference was not statistically significant [$\chi^2 = 2.18$]), but they only averaged 12.2 hours of work per week. Fathers averaged 35.4 hours a week across groups and were generally employed in technical jobs. The annual income for the two groups averaged below $29,000, but there was a wide variance around that mean.

Over 80% of the sample was of European descent, and 98% of the families spoke English as the primary language in their home. Not surprisingly, at 2 weeks following their discharge from the hospital, very few infants (4 of the 52) were placed in child care more than 5 hours per week. The mothers in the high-intensity group reported using less child care than the low-intensity group, although a larger percentage of them reported having employment outside the home and working more hours.

These results are reported in Table 7.2. As can be seen in the table, groups did not differ significantly on any single demographic item. Although the years of the fathers' education approached significance ($t[50] = 1.72$, $p < .10$), the practical difference was between graduating from high school and attending one year beyond high school.

Further results of the parent surveys indicated that 36% of the infants were from families living in Columbus, Ohio, and its immediately surrounding area. The remaining 64% resided in towns and rural areas of central and southeastern Ohio.

Subject Attrition. Table 7.3 presents attrition data for each reassessment. Between enrollment and the initial assessment at two weeks after the infants' discharge from the hospital, two subjects passed away. They were not included in further analysis or comparisons. By the 6-month reassessment, five more infants had died, three families had withdrawn from the study, and one infant was hospitalized. That left 43 total subjects for the 6-month analysis.

All 44 subjects (43 assessed at 6 months and the one that was in the hospital) remaining in the study were assessed at 12 months. One subject was not reassessed at 18 months, but was assessed again at 24 months. Only twenty-seven subjects were assessed at the 36 month reassessment, one additional subject had withdrawn from the study and 16 were not assessed. The number of subjects reassessed at 48 months climbed up to 31, with 12 subjects not returning for reassessment. The subjects who did not return for reassessment were typically willing to remain in the study, they were simply not assessed at the 48 month reassessment. The reasons for non-participation varied, but generally included illness in the family, family problems, the family moving, inability of the staff to locate the subjects, site coordination difficulties, repeatedly failed appointments, or refusal. Standard procedures for locating lost subjects was to contact the next of kin and then send a certified letter.

Table 7.2

Comparability of Groups at Two Weeks Post Discharge on Demographic Characteristics for Columbus Medically Fragile Study

	Active Subjects Enrolled in Study							
	Low Intensity			High Intensity				
Variables	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Adjusted age of child in months at assessment	1.8	(2.2)	26	2.1	(3.3)	26	.17	.14
• Gestational Age	31.0	(4.8)	26	30.8	(5.2)	26	.85	-.04
• Age of mother in years	25.6	(6.9)	26	27.3	(6.3)	26	.35	.25
• Age of father in years	29.2	(8.1)	25	30.4	(7.3)	24	.57	.15
• Percent male*	31	---	26	19	---	26	.34	-.25
• Years of education for mother	12.5	(2.0)	26	12.7	(2.4)	26	.75	.10
• Years of education for father	12.2	(1.2)	26	13.1	(2.5)	26	.09	.75
• Percent with both parents* living at home	77	---	26	81	---	26	.74	.09
• Percent of children who are* Caucasian	85	---	26	81	---	26	.72	-.11
• Hours per week mother employed	9.5	(15.4)	26	12.2	(17.1)	26	.55	.18
• Hours per week father employed	31.6	(18.8)	25	39.2	(16.6)	25	.14	.40
• Percent of mothers employed* outside the home	39	---	26	46	---	26	.58	.16
• Percent of fathers employed as* technical managerial or above	23	---	26	31	---	26	.53	.19
• Total household income♦	$23,130	($16,995)	25	$27,346	($20,412)	26	.43	.24
• Percent of children in daycare* more than 5 hours per week	1	---	26	0	---	26	.60	-.33
• Number of siblings	1.5	(1.8)	26	1.2	(1.3)	26	.48	-.17
• % Sib. receiving Sp. Ed. Services	8	---	26	8	---	26	.99	.00
• Percent with English as primary language	96	---	26	100	---	26	.32	.20

Effect Size (ES) is defined here as the difference between the groups (High Intensity minus Low Intensity) on the $\bar{x}$ scores, divided by the standard deviation of the Low Intensity Intervention Group (see Cohen, 1977; Glass, 1976; Tallmadge, 1977 for a more general discussion of the concept of Effect Size).

* Statistical analyses for these variables were based on a t test where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scored "0."

♦ Income data were categorical and were converted by using the midpoint of each interval into continuous data.

Table 7.3

Subject Attrition at 6-Month Reassessment through 60-Month Reassessment

	Low Intensity Group	High Intensity Group
Enrollment	27	27
Infant Deaths	1	1
Total Enrolled	26	26
6-Month Reassessment+		
Infant Deaths	2	3
Withdrew	1	2
Not Tested*	0	1
Total Assessed	23	20
12-Month Reassessment+		
Withdrew	0	0
Not Tested*	0	0
Total Assessed	23	21
18-Month Reassessment+		
Withdrew	0	0
Not Tested*	1	0
Total Assessed	22	21
24-Month Reassessment+		
Withdrew	0	0
Not Tested*	0	0
Total Assessed	23	21
36-Month Reassessment+		
Withdrew	0	1
Not Tested*	8	8
Total Assessed	15	12
48-Month Assessment		
Not Tested*	8	4
Total Assessed	15	16

* Subjects were not tested for a variety of reasons, including hospitalizations, illness, failed appointments, refusal, and inability to locate subjects.

+ Age corrected for prematurity

Because of the large number of subjects who were not assessed at the 36 and 48 month assessment, further analysis was warranted. These data are presented in Table 7.4. These analysis were completed between subjects who were assessed and those who were not assessed at the 36 and 48 month assessment based on measures taken at the two-week assessment.

Table 7.4

Comparison on 2-Week Assessment Variables Between Subjects Who Completed the 36 and 48 Month Reassessments and Those Who Did Not for the Columbus Medically Fragile Study

		Group Assignment											
		Low Intensity			High Intensity			Reassessment Status					
Variable		$\bar{x}$	SD	n	$\bar{x}$	SD	n	$\bar{x}$	SD	n	F Value	P Value	ES
36-Month Assessment													
Adjusted age in months at Assessment	Tested	1.8	2.3	15	.6	1.7	12	1.2	2.1	27	4.35	.04	-.76
	Not Tested	1.9	2.0	11	3.5	3.8	14	2.8	3.2	25			
BDI Total Raw Score	Tested	23.2	14.9	15	18.2	11.3	12	21.0	13.4	27	1.89	.18	-.49
	Not Tested	22.5	14.8	11	31.5	23.9	14	27.5	20.5	25			
BDI Total Raw Score at 12-month reassessment	Tested	108.9	45.8	15	121.3	45.2	12	114.4	45.1	27	1.36	.25	.37
	Not Tested	90.8	55.9	8	104.9	33.9	8	97.8	45.2	16			
Parenting Stress Index	Tested	241.2	43.7	14	215.1	34.9	12	229.2	41.3	26	.72	.40	-.27
	Not Tested	234.9	53.6	11	244.8	50.4	13	240.3	51.0	24			
Mother's Education	Tested	13.0	1.7	15	13.2	2.3	12	13.1	2.0	27	3.35	.07	.55
	Not Tested	11.7	2.1	11	12.2	2.4	14	12.0	2.2	25			
% of Mothers Employed Outside the Home	Tested	50	50	15	40	50	12	50	50	27	1.21	.28	.40
	Not Tested	20	40	11	50	50	14	30	50	27			
Income	Tested	$27,700	$16,603	15	$33,750	$20,846	12	$30,388	$18,485	27	4.56	.04	.59
	Not Tested	$16,300	$15,962	10	$21,857	$19,059	14	$19,541	$17,688	24			
Family Adaptability (FACES III)	Tested	20.9	4.0	15	27.6	8.6	12	23.9	7.2	27	.58	.45	.19
	Not Tested	22.9	7.2	11	22.1	5.1	14	22.5	6.0	25			
Family Cohesion (FACES III)	Tested	37.4	4.6	15	42.4	6.9	12	39.6	6.2	27	1.60	.21	.40
	Not Tested	38.4	8.1	11	36.1	8.5	14	37.1	8.3	25			
Family Resources (FRS)	Tested	112.9	18.6	15	126.8	18.7	12	119.1	19.6	27	.67	.42	-.21
	Not Tested	122.2	17.6	11	124.1	16.9	14	123.2	16.9	25			
Family Support (FSS)	Tested	23.3	9.5	15	33.7	9.6	12	27.9	10.7	27	.07	.79	-.07
	Not Tested	29.2	9.0	11	28.3	10.7	14	28.7	9.8	25			

(continued)

Table 7.4 (continued)

Comparison on 2-Week Assessment Variables Between Subjects Who Completed the 36 and 48 Month Reassessments and Those Who Did Not for the Columbus Medically Fragile Study

		Group Assignment											
		Low Intensity			High Intensity			Reassessment Status					
Variable		$\bar{x}$	SD	n	$\bar{x}$	SD	n	$\bar{x}$	SD	n	F Value	P Value	ES
48-Month Assessment													
Adjusted age in months at Assessment	Tested	2.5	2.5	15	1.2	2.3	16	1.8	2.5	31	.19	.67	-.16
	Not Tested	.9	1.2	11	3.6	4.2	10	2.2	3.2	21			
BDI Total Raw Score	Tested	27.3	16.8	15	19.6	14.8	16	23.4	16.0	31	.15	.70	-.11
	Not Tested	16.8	7.9	11	34.5	24.4	10	25.2	19.5	21			
BDI Total Raw Score at 12-Month Reassessment	Tested	108.9	45.8	15	121.3	45.2	12	109.0	41.7	31	.73	.54	.07
	Not Tested	90.8	55.9	8	104.9	33.9	8	106.4	55.6	12			
Parenting Stress Index	Tested	230.4	52.2	14	228.4	42.5	16	229.3	46.4	30	.95	.33	-.28
	Not Tested	248.8	40.4	11	234.3	52.6	9	242.3	45.6	20			
Mother's Education	Tested	13.0	2.1	15	12.6	2.6	16	12.8	2.4	31	1.01	.32	.25
	Not Tested	11.7	1.5	11	12.7	2.1	10	12.2	1.8	21			
% of Mothers Employed Outside the Home	Tested	60	50	15	40	50	16	50	50	31	3.05	.04	.40
	Not Tested	10	30	11	60	50	10	30	50	23			
Income	Tested	$26,178	$16,901	14	$24,625	$21,658	16	$25,350	$19,269	30	.77	.51	.01
	Not Tested	$19,272	$17,103	11	$31,700	$18,477	10	$25,190	$18,448	21			
Family Adaptability (FACES III)	Tested	22.7	4.1	15	26.2	8.0	16	24.5	6.6	31	2.94	.09	.48
	Not Tested	20.6	7.1	11	22.2	5.7	10	21.3	6.4	21			
Family Cohesion (FACES III)	Tested	38.1	5.5	15	39.5	8.6	16	38.8	7.2	31	.23	.63	.14
	Not Tested	37.5	7.4	11	38.2	8.2	10	37.8	7.6	21			
Family Resources (FRS)	Tested	116.3	21.2	15	123.6	18.7	16	120.1	20.0	31	.22	.64	-.12
	Not Tested	117.5	14.9	11	128.1	15.7	10	122.5	15.9	21			
Family Support (FSS)	Tested	27.3	11.3	15	32.9	9.2	16	30.2	10.5	31	2.78	.10	.45
	Not Tested	23.7	6.3	11	27.4	11.6	10	25.5	9.2	21			

Subjects who were assessed at the 36 month assessment differed on some 2-week assessment variables from those who were not assessed. Differences were apparent between the two groups on the infants' adjusted age at the 2-week assessment, maternal education, and the families' income. Further analysis showed a significant interaction between the groups on the infants adjusted age. Reframing the analysis from a 2 x 2 ANOVA to a one-way ANOVA showed that, at the 36-month reassessment, children assessed in the high-intensity group were significantly younger at the two-week assessment than the children in the high-intensity group who were not assessed (F(3,48)=2.67, p=.05; LSD procedure). Analysis of maternal education revealed that those who had their children tested had significantly more education than those who did not have their children tested. There was not a significant interaction, nor were there any significant differences between the high-intensity and low-intensity subgroups. Those assessed at the 36-month assessment had a significantly higher income at the initial assessment than those who were not assessed.

The two groups did not differ on other variables including child development (as measured by the BDI) or key family measures. Analysis using the BDI at the initial assessment did not show significant differences, but the failure to reach significance may be attributed to the reliability problems of the BDI on such young children. A second analysis was completed using the assessment at 12 months. Again, there was not a significant difference between those who were assessed and those who were not.

There were fewer differences between those who were assessed and not assessed at the 48-month assessment. Almost half of the mothers who had their children assessed were employed outside the home. This percentage differed from the 30% who did not have their children tested. Further analysis showed a significant interaction between high or low-intensity and tested or not tested (F[3,48] = 7.58; p < .01). The least significant difference procedure revealed that the children who were not tested in the low-intensity group had mothers who were employed outside their home significantly more than the mothers in the low-intensity group who had their children tested or the children who were not tested but were in the high-intensity group. It appears that mothers who worked outside their home in the low-intensity group were more likely to have had their child tested while, in the high intensity group, mothers who did not work outside the home were more likely to have their children tested (though not statistically significant).

There was also a statistically significant difference between those tested and not tested on the initial Family Adaptability and Cohesion Scale (FACES III). The families who were tested scored higher on the adaptability subscale. There was not an interaction effect nor did the high and low-intensity groups differ on their scores.

Although most of the same children were assessed at both reassessments, there were several children who were assessed at one time but not the other, as evidenced by the larger number of children assessed at the 48-month reassessment. Because of the number of subjects who were not assessed at the 36- and 48-month assessments, the results should be viewed with caution; however, because of the few statistically significant differences between the two groups of subjects, the results are likely to still be just as representative of the population.

An analysis of demographic data and measures of child and family functioning indicated no statistically significant differences between the subjects who remained in the study and those lost to attrition on any of the measures. Families of subjects lost to attrition had lower total household income, however, this difference was not statistically significant. To minimize attrition, both the onsite coordinator and the EIRI coordinator maintained [illegible]dated telephone numbers and addresses of the participants and kept in contact with each family at least 3 times each year.

Intervention Programs

The Columbus/MF Project compared a high-intensity intervention program to a low-intensity intervention program. Children in both groups received medical follow-up after their initial discharge from the NICU. The high-intensity intervention group also received coordinated and comprehensive services designed to improve their health and developmental outcomes, and to facilitate their transition from the tertiary hospital to community-based early intervention programs. Table 7.5 provides a summary of the services provided to both groups.

Table 7.5

Services Provided to Infants in the Columbus Medically Fragile Project by Group

High Intensity	Low Intensity
Pre-discharge hospital visits	
Medical follow-up clinics	Medical follow-up clinics
Extensive referral services and follow-up	Referral services
Multidisciplinary center-based intervention	
Multidisciplinary home-based intervention	
IFSP development	
Regular home visits	
Systematic fade-out from hospital services	

High-intensity intervention program. Intervention services provided to the high-intensity intervention group consisted of pre-discharge hospital visits, medical follow-up clinic services, and coordinated multidisciplinary office and home-based early intervention services. The intervention began approximately one month prior to the infant's discharge from the NICU. At that time, 2 or 3 weekly hospital-based visits were initiated by the project's clinical nurse specialist and/or social worker with the infants' families. The visits provided an opportunity for families to establish a support system with ties to both the hospital and their home communities. It also assisted families, prior to discharge, in planning for their infant's home care needs. These services were designed to help families identify and initiate contacts with service providers in their local areas. The transition team which provided the high intensity services included a clinical nurse specialist, with a background in developmental disabilities and parent/child interaction, and the director, with an interdisciplinary background in early intervention. They provided services on a full-time basis. The team also included a neonatologist, an interdisciplinary developmental consultant with a background in occupational therapy and special education, and a social worker, all of whom worked on the team part-time. All of the time spent by these specialists was in addition to the traditional referral and follow-up services provided by other hospital staff to all NICU infants and their families.

The transition team had several roles. First, they worked with the NICU and families in planning discharge from the hospital and in follow-up with local health and developmental services. Second, they assisted families and local service providers in developing and carrying out the Individualized Family Service Plans (IFSP). They also made regular home visits with the families and infants after their discharge from the hospital.

Because medical concerns took a primary role in the first weeks after discharge, local services often included 24-hour home nursing care and the rental or purchase of durable medical equipment such as supplemental oxygen, ventilators, or positioning and feeding equipment. As the infants' medical conditions stabilized in the home settings, additional services were provided. These services included public health, social service, mental health, education, or occupational, physical, and speech therapy.

After hospital discharge, infants received regular medical supervision and developmental evaluation through Columbus Children's Hospital High-Risk Neonatal Follow-up Clinic. The first medical follow-up visit occurred two weeks post-discharge. Additional visits were scheduled for 6, 12, 18, and 24 months of age (ages referenced through 36 months were corrected for prematurity), and yearly thereafter. The clinic was staffed by a neonatologist, social worker, nurse coordinator, and occupational therapist who provided health monitoring and developmental evaluation. Full ancillary services (radiology, pharmacology, ophthalmology, audiology; drug level monitoring, and respiratory therapy) were available in the hospital.

Regular home visits were initiated following the infant's discharge from the hospital and continued for about 12 months. The Columbus/MF project's clinical nurse specialist and developmental consultant attended the home visits with local service providers at least monthly. Whether or not these collaborative home visits were interdisciplinary depended on the concerns surrounding the infant and the family needs. Participants in these collaborative home visits included at least one member of the Columbus/MF project staff, one local service provider, the family (or primary caregiver), and the infant. Post NICU discharge transition team services focused on IFSP (Individualized Family Service Plan) development and implementation and developing home visit collaboration.

Within 45 days after discharge, the developmental consultant and nurse from the transition team arranged an IFSP meeting with the family and identified local service providers to implement goals of the IFSP. They designated a service coordinator, specific providers, and methods of service delivery. Nursing services used a home or community health model and provided intermittent health assessments and family education with the goal of maintaining and improving the infant's health. Nursing services were required between 4 and 24 hours a day. The infants' IFSPs generally included planning for 12-month outcomes in child health, child development and family functioning.

If the child left the hospital with home oxygen therapy, or had experienced a Grade III or IV intracranial hemorrhage, the transition team recommended multidisciplinary developmental intervention for the family. Sparling (1989), in a study of the efficacy of this level of intervention, recommended the above procedures. Intervention focused on a range of developmental areas, not just those in which the child showed a deficit. A certified early intervention professional helped parents learn methods that improve infant's motors skills. This intervention also helped parents integrate activities designed to facilitate cognitive, social, communicative, and adaptive development into play and daily living activities.

Other transition team services varied by community and family. Local community providers and families, assisted by a member of the transition team, developed other services for infants. Single discipline therapy was one alternative, with a therapist focusing on motor or communication skills, for example. They would typically complete exercises with the infant and teach the parents to do these therapies as well.

Regular home visits were scheduled by the transition team nurse and developmental consultant in order to gradually shift responsibility for service to local providers and parents. The basic structure of these visits was to (a) update, (b) plan, (c) practice, and (d) integrate services into the family routine.

The update portion of the visits were to exchange information with the families on their child's progress and review previous ideas. They incorporated a review of the child assessment results and implications, intervention routines as they were integrated into the family's activities, a review of the program, a review of the records, etc.

Planning involved reviewing parent education needs and providing demonstrations, reading materials, videotapes or other materials to assist families with the intervention being implemented to meet identified needs. Health related issues were also reviewed and goals and routines established for maintaining or improving child growth and nutrition. Developmental planning was modeled after the Hawaii Early Learning Profile (HELP) (Furono et al., 1985). This model charts goals incorporating six developmental areas: gross motor, fine motor, social, language, cognitive and self help. It provides charts of developmental milestones which are integrated into an activity-based developmental approach to achieving family and child goals.

During practice, the intervention team engaged in various activities with the child. The team then discussed and decided the appropriateness of the routine for achieving the designated goals. In order to integrate the procedures into the family's routine, the family was asked to complete a calendar tracking how often, how many minutes, and when and where each activity was practiced. The calendar outlined specific activities, directions, and family strategies for achieving the goals for that month. Families were asked to practice three different activities a day and spend a minimum of one to five minutes on each activity.

Local service providers were also encouraged to assist families in locating and using additional community services such as respite care. The project gradually shifted responsibility from the resource team to the communities. The timing of this shift was individualized to meet the family's needs and the ability of the local service providers to take a direct and independent role in working with this special population. The ultimate goal of the project was to transfer full responsibility for the care of the medically fragile infant to local service providers (physicians, public health nurses, early educators, etc.). It was anticipated that these agencies would continue to provide necessary services after the children no longer received transition services from this project.

Low-intensity intervention program. Infants in the low-intensity intervention group received the services that were available to all graduates of the NICU. These services included the same medical and developmental follow-up services of the High-

Risk Neonatal Follow-up Clinic that infants in the high-intensity intervention group received. However, subjects in the low-intensity intervention group did not receive the coordinated transition services or the office and home-based early intervention services available to the high-intensity intervention group. Infants in the low-intensity intervention group who were found to be delayed, at-risk for delay, or in need of community services by the follow-up clinic, were referred to community agencies by the hospital follow-up clinic. These agencies were notified of the referral. These referral agencies were utilized inconsistently at best. Documentation of how often infants in the delayed group accessed referral services is discussed in the treatment verification section that follows.

Intervention Verification

Intervention verification procedures were carried out to ensure that the intervention occurred in accordance with the proposed plan. The verification consisted of data collected on the children, their families, and each intervention program. Verification for infants in the high-intensity intervention group included data on the Individualized Family Service Plan (IFSP) development, a log of individual services provided by the transition team staff who provided home and office services, and additional services data for Physical/Occupational Therapy (PT/OT), early intervention, and public health nursing services. Data on the length and number of transition team visits were kept by the transition team nurse and multidisciplinary development specialists who provided the services. Additional services data and information on IFSPs was also obtained for infants and families in the low intensity intervention.

The transition team nurse and developmental consultant arranged the IFSP meetings for families in the high-intensity group. They contacted local service providers and attempted to get them involved in the IFSP process. A survey at the 18-month reassessment revealed 12 (60%) of the high intensity families reported an

Table 7.11 (continued)

Comparison of Contextual Variables for High-Intensity and Low-Intensity Groups for the Columbus Medically Fragile Study

	Low Intensity			High Intensity				
Variables	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES*
36-Month Reassessment								
• Demographics								
% of children living with 2 parents	93		14	75		12	.22	.59
Annual Family Income	$27,846	($17,199)	13	$38,416	($23,560)	12	.21	.61
• Family Variables								
Family Resources (FRS)[a]	110.8	(20.9)	15	125.3	(10.2)	12	.04	.69
Major Life Events (Holmes & Rahe)%	180.9	(100.2)	15	137.3	(100.7)	12	.27	.44
Negative Events	27.1	(34.9)	15	28.8	(44.9)	12	.92	-.05
• % of Mothers employed outside home	60		14	40		12	.45	.33
• % Fathers employed as Technical/ managerial or above	20		13	30		11	.82	.12
48-Month Reassessment								
• Demographics								
% children living with 2 parents	80		15	56		16	.17	-.57
Annual Family Income	$28,833	($16,646)	15	$26,966	($22,135)	15	.80	-.11
• Family Variables								
Family Resources (FRS)[a]	119.5	(12.7)	15	119.1	(17.2)	16	.95	-.03
Major Life Events (Holmes & Rahe)%	80.2	(51.3)	15	177.3	(119.3)	16	.01	1.89
Negative Events	10.9	(22.7)	15	62.6	(76.1)	16	.02	2.27
• % Mothers employed outside home	50		13	20		16	.12	.68
• % Fathers employed as technical/ managerial or above	20		13	50		11	.12	.74

The family measures offered a perspective into family life. The changing circumstances within the families could also effect the outcome variables and subsequent child and family functioning. To measure these variables, families completed various questionnaires at each reassessment. Family variables that were judged to be subject to change and possibly affect later outcomes are also presented in Table 7.11. Measures included the Family Resource Scale (FRS), Family Inventory of Life Events (FILE), and the Holmes and Rahe Major Life Events (MLE).

The FILE was used for the 12 and 24 month reassessments as a measure of the changes occurring within the family. The life events that occurred for the two groups of families did not differ significantly at either the 12- or 24-month assessment. For the 36- and 48-month reassessments the MLE was used. The MLE differs from the FILE in several aspects. The items are weighted according to the amount of stress they cause in the participant's life. Thus the scores have a wider range and more variability. The MLE is divided into two subscales, the general score and the negative events score. The general score includes all the weights of events listed on the scale and the negative events score is the weighted total of the events classified as negative. These two scores are reported in Table 7.11 for the 36- and 48-month reassessments. Statistically significant differences emerged between the high- and low-intensity groups at the 48 month reassessment on both scales. The families in the high-intensity group reported more life events --both positive and negative-- than families in the low-intensity group. The difference at the 36-month reassessment suggested both groups were more similar than dissimilar. At both reassessments there was a large variation around the mean however, with very large ranges. Differences at the 48-month reassessment may be chance fluctuation of the sample assessed at that time.

There was also a statistically significant difference between groups on the FRS through the 36-month reassessment. The FRS indicates the number of resources the family perceives as available. The parents in the high-intensity group reported more available resources than the low-intensity group. As this is an outcome variable, as well as a contextual variable, the difference may be due to the intervention and reciprocally affect later outcomes. It is likely a real difference, however, in that each group remained relatively stable through the 36-month assessment with scores varying within a range of less than six points throughout the time. This finding is discussed in more detail in the family section of the results and discussion.

A comparison of the medical characteristics of all infants in the high-intensity and low-intensity intervention groups at the time infants were enrolled in the study (Table 7.12) indicated that the groups were similar on most medical measures. There was a statistically significant difference favoring the high-intensity group on oxygen dependence. The effect size approached half a standard deviation. Other relatively large effect sizes favoring the high-intensity group (indicating less medical intrusion) was found on respiratory and feeding status. The less-intensive group tended to be less dependent on technology, however, including a ventilator or pulmonary medications. By the time the infants were discharged from the hospital, the high-intensity group showed statistically significantly differences from the low-intensity group on sensory impairments only. This difference favored the high-intensity group. The results for the infant's 18-month reassessment indicated statistically significant differences on respiratory rate with the low-intensity infants having higher (more severe) scores. At the 36-month reassessment the overall score for medical severity was significantly different between the groups with the high-intensity infants scoring lower (less severe). By the 48-month assessment, however, these differences had disappeared. The medical severity index, a scale incorporating these medical indicators, was used as a covariate when appropriate in the analysis of outcomes presented in subsequent sections of this report.

Results and Discussion

The purpose of the Columbus Medically Fragile study was to compare the effectiveness of service levels to NICU graduates. A high-intensity group received comprehensive and coordinated early intervention services beginning prior to their discharge from an NICU facility. A low-intensity intervention group consisted of infants who received medical follow-up and typical referrals.

Table 7.11

Comparability of Groups on Medical Characteristics for the Columbus Medically Fragile Study

Variable	Low Intensity Group			High Intensity Group			p Value	ES
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n		
Enrollment								
Gestational Age (weeks)	31.0	(4.7)	26	30.8	(5.2)	26	.85	-.04
Birthweight (grams)	1744.2	(861.2)	26	1616.1	(883.6)	26	.60	-.15
% diagnosed w/neurological impairment*	54.0		26	46.0		26	.59	.18
% diagnosed as high risk	15.0		26	19.0		26	.72	-.13
Medical Severity Index'								
Oxygen Dependence	1.6	(1.5)	26	1.0	(1.0)	26	.08	-.40
Respiratory Status	1.3	(1.2)	26	.8	(.9)	26	.15	-.42
Neurological Status	2.2	(1.7)	26	2.1	(1.7)	26	.87	-.06
Technology Dependence	.7	(1.1)	26	1.2	(1.6)	26	.17	.45
Feeding Status	2.5	(1.4)	26	1.9	(1.3)	26	.16	-.43
Sensory Impairment	1.1	(.9)	26	1.1	(1.1)	26	.89	.00
Total	15.3	(4.5)	26	14.2	(6.2)	26	.48	-.24
Initial Assessment (Discharge)								
Medical Severity Index'								
Length of Initial Hosp. Stay (days)	102.4	(75.4)	26	118.6	(91.0)	26	.49	.21
# Days on Ventilator	43.2	(42.2)	26	62.2	(74.6)	26	.26	.45
Days on Oxygen	81.5	(86.2)	26	93.1	(96.0)	26	.65	.13
Total Doses of Medication	7.7	(9.3)	26	6.0	(9.1)	26	.52	-.18
INFANIB Total Score°	58.4	(6.6)	26	58.5	(6.9)	26	.95	.02
Oxygen Dependence at Discharge+	1.1	(1.6)	26	.9	(1.3)	26	.57	-.13
Respiratory Status	1.1	(1.3)	26	.6	(1.1)	26	.15	-.38
Neurological Status	2.2	(1.7)	26	2.3	(1.6)	26	.87	-.06
Technology Dependence	.5	(1.1)	26	1.0	(1.7)	26	.26	-.45
Feeding Status	2.0	(1.6)	26	1.4	(1.1)	26	.12	-.38
Sensory Impairment	1.4	(1.4)	26	.8	(1.2)	26	.09	-.43
Total	15.5	(6.2)	26	13.3	(6.7)	26	.22	-.35
6-Month Reassessment								
Infanib Total Score°	53.6	(11.4)	21	82.2	(113.2)	20	.26	-2.5
12-Month Reassessment								
Days in Hospital Last Year	25.4	(39.9)	21	42.8	(92.4)	20	.44	-.43
Infanib Total Score°	63.1	(22.7)	23	59.3	(21.7)	20	.58	-.17
18-Month Reassessment								
Oxygen Dependence+	.6	(1.6)	22	.5	(1.4)	21	.88	.06
Respiratory Rate+	1.3	(1.7)	22	.6	(1.2)	21	.10	-.41
Technology Dependence+	.8	(1.3)	22	.8	(1.6)	21	.98	.00
Feeding Status+	1.4	(2.2)	22	.5	(1.5)	21	.11	-.41
Rehospitalization Days	.7	(1.2)	22	.6	(1.2)	21	.77	-.08
24-Month Reassessment								
Oxygen Dependence+	.4	(1.3)	20	.3	(1.1)	20	.69	-.08
Respiratory Rate+	.2	(.7)	20	.2	(.7)	20	1.00	.00
Technology Dependence+	.8	(1.4)	20	.4	(1.2)	20	.33	-.29
Feeding Status+	1.2	(2.1)	20	.5	(1.5)	20	.27	-.33
Hospitalization days	8.9	(21.9)	23	5.1	(7.2)	21	.46	-.17
36-Month Reassessment								
Health Index Total	3.7	(1.8)	15	2.1	(1.7)	12	.02	-.89
Hospitalization days	4.5	(7.2)	15	1.5	(3.1)	12	.19	-.42
48-Month Reassessment								
Health Index Total	2.5	(1.5)	15	2.5	(1.9)	13	.99	.00
Hospitalization Days	10.5	(32.2)	14	.3	(.6)	16	.22	.32

* To be included in the study, infants were diagnosed with either BPD or neurological impairment. Those infants not diagnosed with neurological impairment were included because of BPD.

+ Scores ranged from 1 to 5 with high scores considered more severe.

' High scores are considered worse.

° The INFANIB analysis was conducted using raw scores. A higher score indicates greater neurological maturity.

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Comparison of Groups on Initial Measures

As Table 7.2 showed, the families did not differ according to their by group assignment on most demographic variables. The father's years of education was statistically significant, but in reality was a small practical difference. Nevertheless, the variable was considered as a possible covariate in subsequent analyses.

Similar to the demographic variables, there were no statistically significant differences between the high- and low-intensity groups on the initial two-week post-discharge assessments. On the initial child development measure, the BDI, the children were functioning (on average) at the lower end of the scale. As Table 7.13 indicates, children scored at or below the 38th percentile across the subscales of the BDI. There were no significant differences between the two groups on the developmental measure.

Family measures collected at the time of the two-week post discharge included the Parenting Stress Index (PSI), Family Adaptability and Cohesion Evaluation Scales (FACES), the Family Resource Scale (FRS), Family Support Scale (FSS) and the Family Inventory of Life Events (FILE). Although there were significant differences between the high- and low-intensity groups on the FRS and FSS at the initial post-discharge assessment, they could not be included as initial pre-intervention assessments. The PSI, FACES, and FILE did not show a significant difference between groups, but likewise, they could not be included as initial preintervention assessments either. The family measures are suspect as initial assessments because of the intervention received between enrollment and the infant's discharge from the hospital. Infants were hospitalized for up to 6 months prior to discharge from the NICU. This meant that many families in the more-intensive intervention received a significant number of visits prior to the initial family assessment at two weeks following discharge from the NICU. During this period, services focused on helping the family prepare

Table 7.13

Comparability on Assessment Measures for the Low-Intensity and High-Intensity Groups at the Columbus Medically Fragile Project

	Low-Intensity Group				High- Intensity Group					
Variable	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	p Value	ES
Adjusted age at assessment in months	1.8	(2.2)		26	2.1	(3.3)		26	.68	.14
Battelle Developmental Inventory (BDI)										
Personal/Social	6.0	(4.1)	10	26	7.9	(6.6)	12	26	.21	.46
Adaptive	3.8	(2.8)	10	26	4.5	(3.9)	18	26	.47	.25
Motor	4.9	(4.4)	10	26	5.0	(4.7)	10	26	.98	.02
Fine	2.2	(1.6)	34	26	2.5	(1.9)	38	26	.48	.19
Gross	2.7	(3.3)	8	26	2.3	(3.1)	6	26	.67	-.12
Communication	4.7	(2.1)	22	26	4.9	(2.6)	22	26	.82	.10
Receptive	3.8	(1.5)	38	26	4.1	(2.0)	38	26	.48	.20
Expressive	1.0	(1.3)	18	26	.8	(1.3)	18	26	.60	-.15
Cognitive	3.4	(2.9)	34	26	3.0	(3.5)	34	26	.61	-.14
TOTAL	22.9	(14.5)	6	26	25.3	(20.0)	10	26	.61	.17
Infant International Neurological Battery	58.4	(6.6)		26	58.5	(6.9)		26	.96	.02
Parenting Stress Index (PSI)										
Total	238.5	(47.4)	70	25	230.5	(45.4)	63	25	.55	.17
Child-Related	109.8	(21.8)	78	25	113.5	(25.1)	85	25	.58	-.17
Other Related	128.7	(27.6)	65	25	117.0	(26.5)	44	25	.13	.42
Family Adaptation and Cohesion Evaluation Scales (FACES III)										
Adaptability	21.8	(5.6)		26	24.7	(7.4)		26	.12	.52
Cohesion	37.8	(6.2)		26	39.0	(8.3)		26	.56	.19
Family Resource Scale (FRS)	116.8	(18.4)	48	26	125.3	(17.4)	63	26	.09	.46
Family Support Scale (FSS)	25.8	(9.6)	45	26	30.8	(10.4)	63	26	.08	.52
Family Inventory of Life Events (FILE)	11.4	(5.2)	34	26	11.8	(7.6)	29	26	.83	-.08

for the transition of the infant to the home. Transition team members believed there was a high probability that these measures of family functioning could have been influenced by the services provided. These measures while informative, are inappropriate pre-intervention measures. They are presented in Table 7.13 for information purposes only. The measures are also presented later with the outcome measures.

While families in the more intensive intervention received significant quantities of intervention from the transition team between the time of enrollment and the two-week post-discharge assessment, the services were not focused on child

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development activities. Consequently, measures of child functioning collected at the two-week post-discharge assessment are not analyzed as outcomes, but as initial measures.

Covariate Selection

Analysis of covariance (ANCOVA) procedures were used to evaluate differences between groups on measures of child and family functioning following intensive, coordinated early intervention transition services to one group of infants and less intensive routine medical follow-up for the other group. Analysis of covariance procedures were used for two reasons: (a) to increase the statistical power of the study by reducing error variance; and (b) to adjust for any pretreatment differences which were present between the groups. In either application, the degree to which analysis of covariance is useful depends on the correlation between the covariate(s) selected and the outcome variable for which analyses are being done. However, since one degree of freedom is lost for each covariate used, it is generally best to use a limited number of covariates in any given analysis. All pretest and demographic variables were considered as potential covariates. The final selection of covariates depended on a judgment of which variable or set of variables could be used to maximize the correlation or multiple correlation with the outcome variable in question and still include those demographic or initial assessment variables for which there were the largest pretreatment differences. For example, age at the initial assessment and level of severity at discharge were used as covariates for the first reassessment's Bayley Mental Developmental Index scores. The combination of these variables reduced the amount of unexplained variance in the first reassessment Bayley scores better than other combination of initial assessment or demographic variables.

Although sample sizes for this study are as large or larger than previous early intervention studies with these types of children, the statistical power of the analysis is still a concern. By setting the alpha level for all tests of statistical significance at $p \leq .10$, and by using analysis of covariance procedures, the statistical power of the analyses was substantially increased. According to Hopkins (1973) and Cohen (1977), in those cases where a covariate or set of covariates could be found which correlated with the dependent variable in question (which was almost always the case in these analyses), and with alpha set at $p \leq .10$, the statistical power was approximately 94% for finding moderate sized differences (defined by Cohen as differences of a half a standard deviation).

Effects of High Intensity vs. Low Intensity Intervention on Measures of Child Functioning

Measures of child functioning across reassessments showed few statistically significant differences between the high- and low-intensity groups (see Table 7.14). The average effect size across all reassessments equated to -.02, again revealing little if any effect due to the intervention or group assignment. Despite the lack of statistically significant results, individual reassessments warrant further investigation and explanation.

At the 6-month reassessment (age corrected for prematurity) infants were administered the Bayley Scales of Infant Development (Bayley) and the Infant International Neurological Battery (INFANIB). Neither assessment showed significant differences between groups after preassessment variables were used as covariates. The statistical power was deemed appropriate as the covariates both correlated with the dependent variables and were significant in multiple regressions across each of the reassessments the measures were used. The covariates, where more than one was chosen, were also minimally correlated with each other thereby minimizing colinearity. The mental processing subscale of the Bayley, while failing to reach statistical significance, had an effect size of .53. This slightly over one-half standard deviation suggests an immediate cognitive benefit to the high-intensity

Table 7.14

Summary of Reassessment ANCOVAs on Measures of Child Functioning for Alternative Intervention Groups in the Columbus Medically Fragile Study

		Low Intensity Group				High Intensity Group						
	Covariate*	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES
6-MONTH REASSESSMENT												
Adjusted Age in Months		5.6	(.7)		21	5.6	(.6)		20	.01	.92	.00
INFANIB' Total (range:20 to 100)	1,8	53.6	(11.4)	55.6	21	56.9	(10.7)	54.9	20	.04	.84	-.06
Bayley'												
Motor	9,10	69.4	(25.1)	73.4	23	81.2	(23.4)	77.3	22	.46	.50	.26
Mental	1	73.9	(21.3)	78.5	23	91.0	(33.1)	86.3	22	1.09	.30	.53
Carey Infant Temperament Scale												
Distractibility	9,11	249.1	(39.5)	240.4	17	243.5	(76.0)	252.2	19	.61	.44	-.14
Approach/Withdrawal	12	265.2	(78.1)	268.0	17	257.5	(55.1)	254.7	19	.40	.53	-.10
Adaptability	12,13	266.3	(75.7)	256.2	16	252.4	(46.9)	262.5	18	.18	.68	-.18
Intensity	14	326.6	(57.9)	232.0	17	344.5	(41.6)	348.1	19	2.30	.14	.31
Mood	15	320.4	(58.2)	318.4)	17	326.9	(95.5)	328.9	19	.19	.67	.11
Persistence	16	335.8	(66.0)	339.5	17	333.8	(77.2)	330.1	19	.16	.70	-.03
Activity		395.2	(56.1)	395.2	17	396.3	(55.6)	396.3	19	.00	.95	.02
Rhythmicity	9	1.4	(1.5)	308.0	17	.9	(1.2)	296.5	19	.09	.76	-.33
Threshold	14,17	402.6	(65.6)	399.7	17	403.8	(69.0)	406.8	19	.13	.73	.02
12-MONTH REASSESSMENT												
Adjusted Age in Months		12.1	(.8)		23	12.1	(.7)		19	.03	.87	.00
Battelle Developmental Inventory'												
Personal/Social	1[a]	26.6	(10.4)	27.3	23	31.6	(7.3)	30.8	21	1.70	.20	.34
Adaptive Behavior	1	19.7	(11.1)	21.2	23	23.0	(10.1)	21.6	21	.01	.91	.04
Motor	1	25.9	(14.9)	28.2	23	27.9	(14.4)	25.6	20	.49	.49	-.17
Communication	1	16.0	(7.7)	16.9	23	18.8	(6.6)	17.8	20	.18	.68	.12
Cognitive	1	14.0	(7.2)	14.9	23	14.5	(5.9)	13.6	20	.47	.50	-.18
TOTAL	1	102.6	(49.1)	109.3	23	114.8	(40.9)	108.1	20	.01	.92	-.02
General Health		1.6	(.7)	1.7	17	1.7	(.5)	1.6	21	.26	.62	-.14
Infanib' Total (range 20 to 100)	1	63.1	(22.7)	65.0	23	59.3	(21.7)	57.4	20	1.30	.26	-.34
18-MONTH REASSESSMENT												
Adjusted Age in Months		20.1	(1.3)		22	20.1	(1.5)		21	.00	.99	.00
Vineland'												
Communication	2	78.9	(10.6)	78.7	22	80.2	(11.5)	80.4	21	.37	.55	.19
Daily living skills	9,10	77.3	(14.3)	78.9	22	78.9	(14.4)	77.3	21	.17	.68	-.11
Social	2	83.2	(15.9)	82.8	22	89.5	(12.0)	89.8	21	3.73	.06	.40
Bayley'												
Motor	1	69.5	(21.3)	71.8	22	67.3	(20.5)	65.0	21	1.28	.27	-.23
Mental	1,4	71.6	(23.9)	74.4	22	73.7	(23.6)	70.9	21	.28	.60	-.04

INFANIB and BDI statistical analyses were conducted using raw scores for each of the scales.

Effect Size (ES) is defined here as the difference between the groups (High Intensity minus Low Intensity) on the $\bar{x}$ scores, divided by the standard deviation of the Low-Intensity Intervention Group (see Cohen, 1977; Glass, 1976; Tallmadge, 1977 for a more general discussion of the concept of Effect Size). A positive ES difference indicates a variable which is more favorable for the high-intensity group, while a negative ES is more favorable for low-intensity group subjects.

Bayley analysis was conducted using standard scores.

- Analysis is based on scores that range from 6 to 24.

- Child's Medical Severity Index score correlated highly with the outcome measures for the 12 and 24 month measures, but their neurological status correlated higher at the 36 and 48 month assessments.

Table 7.14 (continued)

Summary of Posttest ANCOVAs on Measures of Child Functioning for Alternative Intervention Groups for the Columbus Medically Fragile Study

		Low Intensity Group				High Intensity Group				ANCOVA	p	
	Covariate♦	x̄	(SD)	Adj.x̄	n	x̄	(SD)	Adj.x̄	n	F	Value	ES
24-MONTH REASSESSMENT												
Adjusted Age at Reassessment in Months		24.7	(1.5)		23	25.3	(2.3)		21	.81	.37	.40
Battelle Developmental Inventory' (BDI)												
Personal/Social	1[a]	55.7	(24.3)	58.2	23	58.6	(21.0)	56.1	21	.11	.74	-.09
Adaptive Behavior	1	36.7	(17.9)	39.1	23	39.9	(15.6)	37.5	21	.14	.71	-.09
Motor	1,3	53.8	(30.4)	59.0	22	53.2	(26.2)	48.0	21	2.27	.14	-.36
Communication	1	27.8	(10.5)	29.0	23	31.9	(7.0)	30.8	21	.54	.47	.17
Cognitive	1,5	20.6	(8.4)	21.2	23	21.7	(7.7)	21.1	21	.00	.99	-.01
TOTAL	1	194.9	(87.3)	205.0	23	205.3	(71.5)	195.2	21	.20	.65	-.11
General Health		1.7	(.7)	1.78	23	2.2	(.7)	2.2	21	4.77	.04	.53
36-MONTH REASSESSMENT												
Adjusted Age at Reassessment in Months		38.4	(2.5)		15	38.4	(2.4)		12	.00	.98	.00
Battelle Developmental Inventory+ (BDI)												
Personal/Social	2[a]	88.3	(35.0)	92.2	15	90.0	(30.0)	86.1	12	.47	.50	-.17
Adaptive Behavior	2	54.3	(23.0)	56.8	15	52.8	(20.0)	50.2	12	1.19	.29	-.29
Motor	2,4	66.0	(33.8)	70.2	14	71.1	(32.0)	66.9	12	.12	.74	-.10
Communication	2	41.5	(17.3)	43.4	15	45.6	(16.0)	43.7	12	.01	.94	.01
Cognitive	2,4	29.4	(1.8)	31.0	14	31.8	(1.2)	30.1	12	.07	.79	-.05
TOTAL	2,12	274.2	(116.9)	300.6	14	291.2	(105.0)	264.8	12	1.47	.24	-.31
General Health	1	1.8	(.6)	1.9	15	1.9	(.5)	1.8	12	.54	.47	-.17
48-MONTH REASSESSMENT												
Chronological Age at Reassessment in Months		51.7	(2.1)		15	50.7	(2.9)		16	1.2	.28	-.48
Battelle Developmental Inventory+ (BDI)												
Personal/Social	2[a]	104.5	(46.1)	107.0	15	100.1	(43.7)	97.7	16	.49	.49	-.20
Adaptive Behavior	2	62.0	(30.0)	63.6	15	59.8	(26.7)	58.2	16	.43	.52	-.18
Motor	2	79.2	(40.6)	81.1	15	73.3	(37.1)	71.3	16	.67	.42	-.24
Communication	2	50.4	(26.9)	51.7	15	53.7	(24.9)	52.4	16	.01	.93	.03
Cognitive	2,12	37.8	(22.9)	38.7	14	40.1	(20.4)	39.2	16	.00	.95	.02
TOTAL	2	336.5	(159.3)	344.7	15	326.4	(145.5)	318.1	16	.35	.56	-.17
Parent Protection Scale												
TOTAL		37.7	(7.1)	37.7	3	36.1	(5.9)	36.1	9	.14	.71	-.23
Child Vulnerability TOTAL		8.3	(5.5)	8.3	3	8.7	(4.6)	8.7	7	.01	.91	.07
Perceived Competence and Social Acceptance'												
Cognitive Competence		8.0	(10.3)	8.0	15	6.5	(10.2)	6.5	13	.16	.70	-.15
Peer Acceptance		7.2	(9.5)	7.2	15	6.8	(10.7)	6.8	13	.01	.91	-.04
Peer Competence		7.8	(10.0)	7.8	15	6.0	(9.8)	6.0	13	.23	.64	-.18
Maternal Acceptance		8.0	(10.3)	8.0	15	6.8	(10.7)	6.8	13	.10	.76	-.12
General Health		1.8	(.7)	1.8	14	1.9	(.3)	1.9	16	.21	.65	.14

(see previous page for notes)

group, although the benefit apparently wore off before the Bayley was used again at the 18-month reassessment.

Mothers completed the Carey Infant Temperament Scale (ITQ) at the 6-month reassessment. This measure includes nine subscales that, when evaluated as a whole, aid in the classification of infants into one of several diagnostic temperament clusters. Although temperament is hypothesized to be an innate characteristic, research has shown that the current instrument measures the mother's perception of her infant and not the infant (Vaughn, Taraldson, Crichton, & Egeland, 1981). Because mothers' perceptions are relative and can be changed, the ITQ is included as an outcome measure. The high-intensity intervention should have had a positive influence on mother's perception of their infants and given them additional power in dealing with their six-month-old infant. The p-values for the nine scales failed to reach significance between the two groups, and the effect sizes were not large enough to warrant further investigation.

However the diagnostic clusters of the ITQ did show interesting differences. Analysis of the differences must be subjective because of the lack of statistical procedures for this form of data with this many categories and subjects. Traditional parametric and non-parametric tests of significance are inappropriate. Parametric tests are inappropriate because of the nominal nature of the data. Non-parametric tests yield spurious results because of the low expected frequency in each cell. Visual examination of Figures 7.2 and 7.3 show how the two groups differed. The categorical mode for the low-intensity group placed the infants in the difficult category. Mothers in this group perceived their infants to be arrhythmic, likely to withdraw from interactions, slow to adapt to routines, intense, and show a generally negative mood when rated against other infants. Only 16% of mothers in the high-intensity group rated their infants as difficult. They generally perceived their infants as "intermediate high." This category is comparable to the difficult category, though the ratings are not as extreme. Twenty-six percent of the high-

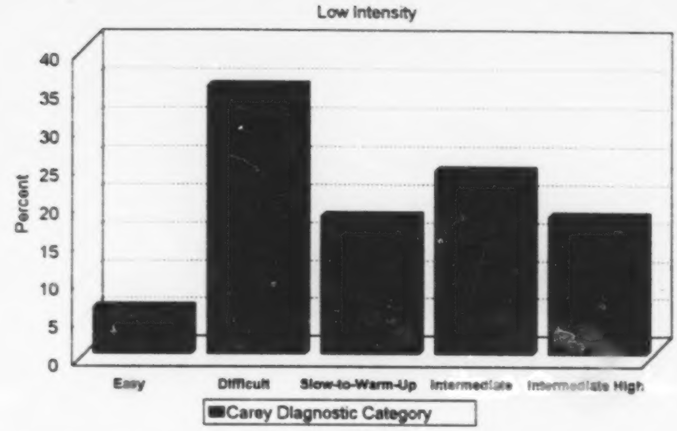

Figure 2. **Bar Chart showing the percentage of infants in each category of the Infant Temperament Questionnaire for the Columbus Medically Fragile Low-Intensity group.**

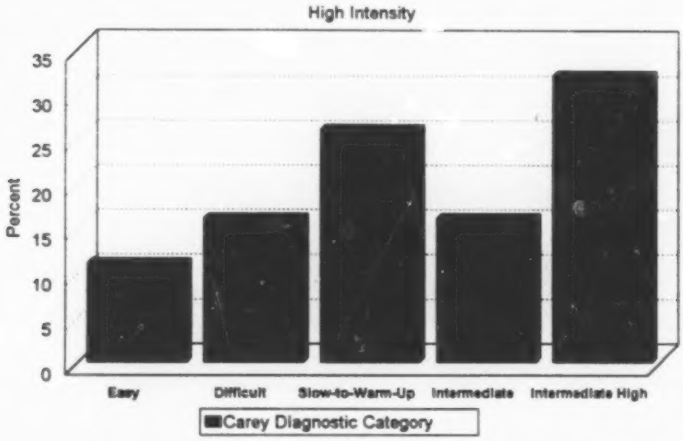

Figure 3. **Bar Chart showing the percentage of infants in each category of the Infant Temperament Questionnaire for the Columbus Medically Fragile High-Intensity group.**

intensity mothers perceived their infants as slow-to-warm-up. This compared to 24% of the mothers in the low-intensity group who rated their infants' intermediate low--a category reserved for infants whose temperament is perceived as easier than intermediate high but much more difficult than easy. The easy category was the one that was used the least, only 6% in the low-intensity group compared to 11% in the high-intensity group.

The Vineland Adaptive Behavior Scales were administered at the 18-month reassessment. While the communication and daily living skills scales were not statistically significantly different, the social scale did show a statistically significant difference. The children in the high-intensity groups were seen as being more social. This is contrary to the personal/social domains of the BDI assessments administered six months before and after this assessment, but is consistent with the different ITQ diagnostic categories of difficult and intermediate high. One possible solution may be that the BDI personal/social domain is not as sensitive to social skills as the Vineland for infants.

The BDI was administered at the 12, 24, 36, and 48 month assessments. Similar to the initial assessment, no significant differences emerged for any subscale or for the total score at any reassessment. The effect sizes were likewise generally negligible. Interestingly, while the effect sizes were minimal, the 24, 36 and 48-month reassessments generally showed negative effect sizes while the assessment at the 12-month reassessment showed positive effect sizes. The samples appear to be different at the 36 and 48-month assessments also. Due to the different samples at these two reassessments (because of non-assessment), the variables that correlated with the BDI for covariate selection changed. For the 12 and 24-month reassessments, scores on the Medical Severity Index from the enrollment were generally seen as an appropriate covariate. The infant's neurological status at enrollment appeared to be a better choice for the 36 and 48-month reassessments, however.

Analysis of the BDI total scores at each reassessment placed the sample, as a group, below the first percentile. Adding one standard deviation (as defined by the group assignment) to the mean for each group placed children scoring that highly in increasingly higher percentiles as they matured. For example, at the 12-month reassessment, those scoring one standard deviation higher than the mean were in the forth percentile. Children scoring one standard deviation above the mean of the group at the 48-month reassessment placed in the thirty-second percentile. This upper score gave those children an age equivalent score of 50 months (the actual age for the group as a whole was 51.2 months). Age equivalent scores for children who obtained the group mean score were only 29 months, 22 months below their actual age. While the means remained low relative to the normative sample, children who scored in the upper range of the group showed gains relative to the normative sample.

Starting at the 12-month reassessment the parents were asked to rate their child's health. The scale asked for the parents' perceptions of their child's health compared to the health of other children. The three-point scale asked if their child was less healthy, about the same, or more healthy than other children. At the 24-month reassessment parents in the high-intensity group had an average rating for their children as "about the same as other children." This was a statistically significant difference from the low-intensity group who averaged slightly below "about the same as other children". The difference faded in the following years, possibly because of a chance finding, but more likely because of the different samples. For the 36 and 48-month assessments parents in the low-intensity group rated their children's health as increasing while parents in the high-intensity group fluctuated, but never dropped much below the middle rating.

The Preschool Pictorial Perceived Competence and Social Acceptance Scale was administered to children at the 48-month reassessment. The scale did not show any statistically significant differences between the groups. Examination of the scores showed that most children were scoring at the lower end of the scale, suggesting it may be inappropriate for these children. Anecdotal information from the assessment administrators confirmed that very few children understood what they were supposed to do for the assessment. For those who did respond, most appeared to respond in a random fashion.

Across reassessments and across time, few differences emerged between the children in the high- and low-intensity groups. Outcome measures for the children did not show any consistent group differences. Despite the lack of statistically significant differences, interesting knowledge about the infants was gained. Children in the low-intensity group were more likely to be classified as difficult on the ITQ than children in the high-intensity group. It is conceivable that the intervention made a difference in the mother's perception of her infant, thereby theoretically increasing their positive interactions or increasing their optimistic outlook. Children scoring on the upper end (relative to this sample) of the BDI appeared to have made gains relative to their peers. Children who scored at or below the mean stayed behind their same age peers. This observation warrants further attention.

The lack of differences on child measures may also say little about the intervention. While it appears that increased services did not directly impact child functioning as measured by these instruments, it did not hurt their development either. If the intervention had an affect in other areas -such as a decreased probability of needing further early intervention services- the increase in early services may have been worth the cost. From a parents perspective, if they think it will help, and it is unlikely to hinder development, let them choose if the intervention is worth the extra time and effort. Chances are, they know what will make a difference more than a stranger who interacts with the family for a very brief period. These results call for a more individual approach to early intervention, not a program for the masses where one amount is the best for everybody. An intervention of this sort may increase the parent's perception of their infant and have an indirect impact as the children mature.

Effects of Alternative Forms of Intervention on Measures of Family Functioning

Whether or not the intervention had an effect on the families' functioning was a primary importance to the current study. Measures of family functioning were gathered at each reassessment. Consistent measures included the Parenting Stress Index (PSI), the Family Support Scale (FSS), and the Family Resource Scale (FRS).

Other measures included the Family Adaptation and Cohesion Evaluation Scales (FACES) and the Parent Self-Awareness Scale (PSAS).

The FRS was used as a measure of the resources available to the family. These resources included various forms of general resources, physical resources, time availability, and external support. As a contextual variable, the FRS showed statistically significant differences through the 36 month reassessment (refer to Table 7.11). Resources are typically considered outside a researchers control for this form of early intervention, but a goal of the intervention was to aid families in finding appropriate services for their infants, thereby adding to the family's resources. As an outcome variable, using analysis of covariance techniques, the FRS showed statistically significant differences between the high- and low-intensity groups at the 12 and 36-month assessments. Although not statistically significant at the initial assessment or the 6, 18, or 24-month assessment, the results favored the high-intensity group through the 36-month assessment. The 48-month assessment, however, provided results that were equivalent between the groups (see Table 7.15).

To further analyze the results, it was hypothesized that the intervention would most likely affect the time availability and external supports scale of the FRS. The external support scale was statistically significant between the groups for only the 36-month reassessment. The results again favor the high-intensity group suggesting that they perceived more external supports at that time. However, this difference is not statistically significant at the other reassessments and may be a chance finding. Time availability, on the other hand, showed significant differences at the 12, 24, and 36 month assessments. At each reassessment the families in the high-intensity group perceived they had more time availability than their low-intensity counterparts.

The PSI was administered at the initial assessment, at the 12, 24, 36 and 48-month reassessments. The initial assessment is included with these analyses because of substantial amounts of intervention that occurred before the initial assessment.

Table 7.15

Summary of ANCOVAs on Measures of Family Functioning for Alternative Intervention Groups for the Columbus Medically Fragile Study

		Low Intensity Group				High Intensity Group						
	Covariate♦	$\bar{X}$	(SD)	Adj.$\bar{X}$	n	$\bar{X}$	(SD)	Adj.$\bar{X}$	n	ANCOVA F	P Value	ES
INITIAL ASSESSMENT												
Parenting Stress Index♣ (PSI)												
Child Related	1	109.8	(21.8)	109.3	25	113.5	(25.1)	113.9	25	.51	.48	-.21
Other Related	2	128.7	(27.6)	126.2	25	117.0	(26.5)	119.5	25	.80	.38	.24
TOTAL	2	238.5	(47.4)	234.5	25	230.5	(45.4)	234.5	25	.00	.99	.00
Family Adaptation and Cohesion· Evaluation Scales (FACES)												
Adaptation	3	21.8	(5.6)	21.9	26	24.7	(7.4)	24.5	26	2.20	.14	.46
Cohesion	2,4	37.7	(6.3)	38.5	25	39.0	(8.3)	38.2	26	.04	.85	-.05
Family Support Scale (FSS)	5	25.8	(9.6)	25.9	26	30.8	(10.4)	30.6	26	3.10	.09	.49
Family Resource Scale (FRS)	2,4	116.0	(18.3)	117.4	25	125.3	(17.4)	123.9	26	1.90	.17	.36
6 MONTH REASSESSMENT												
Family Support Scale	1,2	29.0	(12.4)	29.3	21	32.1	(8.4)	31.8	20	.65	.42	.20
Family Resource Scale	3,4	120.3	(12.5)	122.1	21	128.6	(13.8)	126.8	20	2.21	.15	.38
12-MONTH REASSESSMENT												
Parenting Stress Index♣ (PSI)												
Child Related	14	111.1	(19.3)	110.3	22	105.3	(22.9)	106.1	21	.46	.50	.22
Other Related	12,13	132.8	(23.8)	128.0	22	124.8	(31.2)	129.6	21	.06	.81	-.07
TOTAL	13,14	244.0	(38.9)	239.5	22	230.1	(51.2)	234.6	21	.16	.69	.13
Family Adaptation and Cohesion· Evaluation Scales (FACES)												
Adaptation	9,10	21.9	(7.0)	22.0	22	23.3	(8.5)	23.3	19	.31	.58	.13
Cohesion	17	37.3	(6.6)	38.0	23	35.5	(9.5)	34.9	21	1.80	.19	-.36
Family Support Scale (FSS)	4	25.7	(10.9)	24.9	23	29.0	(10.0)	29.7	20	2.44	.13	.34
Family Resource Scale (FRS)	7,2,5	116.5	(17.5)	116.9	22	126.9	(16.3)	126.4	20	4.00	.05	.54
External Support	2	23.3	(4.3)	23.5	23	24.4	(4.5)	24.2	20	.34	.56	.16
Time Availability	4,7	37.9	(10.7)	37.6	23	43.6	(11.1)	43.9	20	4.20	.05	.59

Effect Size (ES) is defined here as the difference between the groups (High Intensity minus Low Intensity) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation of the Less Intensive Intervention Group (see Cohen, 1977; Glass, 1976; Tallmadge, 1977 for a more general discussion of the concept of Effect Size). For the PSI and FILE, the numerator for the ES is calculated as: Less Intensive - More Intensive, as lower scores are preferred. A positive ES difference indicates a variable which is more favorable for the high-intensity group, while a negative ES is more favorable for low-intensity group subjects.

♣ Low scores indicate less stress.

· Scores for each subscale of the FACES are derived based on linear scoring where high scores are preferred.

♦ 1 = Hours employed per week--mother; 2 = highest completed year of education--mother; 3 = mother's occupational SES category; 4 = Sensory impairment at enrollment; 5 = Total yearly income for household; 6 = Number of days on ventilator; 7 = Family Index of Life Events and Changes (FILE); 8 = Gestational age (weeks); 9 = Dad's age; 10 = No. days of oxygen dependency; 11 = Age at diagnosis; 12 = Parenting Stress Index parent related subscale at assessment; 13 = Family Resource Scale Total Score; 14 = Parenting Stress Index Total Score; 15 = Parenting Stress Index Child Related Subscale at Assessment; 16 = Respiratory Status; 17 = Cohesion, 18 = Father's Occupational Status.

Table 7.15 (continued)

Summary of ANCOVAs on Measures of Family Functioning for Alternative Intervention Groups for the Columbus Medically Fragile Study

		Low Intensity Group				High Intensity Group						
	Covariate◆	$\bar{X}$	(SD)	Adj.$\bar{X}$	n	$\bar{X}$	(SD)	Adj.$\bar{X}$	n	ANCOVA F	P Value	ES
18-MONTH REASSESSMENT												
Family Support Scale	1	23.9	(8.9)	24.1	22	28.0	(10.0)	27.7	21	1.80	.19	.40
Family Resource Scale	1,2,3	118.0	(17.4)	118.3	21	120.8	(16.3)	120.5	20	.25	.62	.13
24-MONTH REASSESSMENT												
Parenting Stress Index◆												
Child Related	14	117.3	(19.0)	116.4	22	110.7	(17.3)	111.6	21	.88	.36	.12
Other Related	12,13	136.4	(26.7)	132.4	22	118.9	(21.4)	122.9	21	2.33	.14	.50
TOTAL	13,14	253.7	(40.2)	249.4	22	229.6	(33.8)	233.9	21	2.49	.12	.36
Family Adaptation and Cohesion Evaluation Scales (FACES)												
Adaptation	9,10	21.0	(7.1)	21.0	22	21.3	(6.3)	21.3	18	.04	.85	.01
Cohesion	17	36.3	(6.4)	37.5	23	39.7	(5.9)	38.5	20	.39	.54	.25
Family Support Scale	2,11	24.7	(7.3)	25.1	23	26.8	(11.6)	26.3	21	.25	.62	.17
Family Resource Scale	4,5	111.3	(18.5)	114.9	23	126.1	(13.8)	122.6	21	2.60	.12	.42
External Support	1,5	22.4	(4.2)	22.8	23	24.6	(3.5)	24.2	21	1.50	.23	.33
Time Availability	4,2,5	35.0	(9.2)	36.2	23	42.9	(9.6)	41.2	21	3.60	.06	.54
36-MONTH REASSESSMENT												
Family Support Scale	2,11	26.9	(10.5)	27.0	15	29.4	(9.1)	29.4	12	.59	.45	.23
Family Resource Scale		110.8	(20.9)		15	125.3	(10.2)		12	4.8	.04	.69
External Support		21.4	(4.9)		15	24.8	(3.4)		12	3.0	.10	.69
Time Availability	18	32.8	(11.5)	33.1	15	41.6	(6.6)	41.3	12	4.5	.04	.71
Parent Self-Awareness TOTAL		41.3	(8.1)	41.3	15	46.3	(7.6)		12	2.67	.12	.62
Parenting Stress Index-Short Form												
Parent Distress	15	29.5	(9.2)	28.3	14	22.1	(7.3)	23.3	12	1.92	.18	+.54
Parent/Child Dysfunc.	15	22.9	(5.6)	21.6	14	18.1	(5.0)	19.4	12	1.11	.30	+.39
Difficult Child	16	29.6	(7.3)	30.1	15	24.8	(8.1)	24.3	12	4.21	.05	+.79
48-MONTH REASSESSMENT												
Family Support Scale	2,11	25.9	(8.7)	25.7	15	30.1	(9.9)	30.3	16	1.90	.18	.53
Family Resource Scale		119.5	(12.8)		15	119.1	(17.2)		16	.0	.95	-.03
External Support	18	24.1	(3.4)	24.5	15	23.0	(4.4)	22.7	16	1.7	.21	-.53
Time Availability	18	37.5	(7.6)	38.3	15	38.7	(9.7)	37.9	16	.02	.88	-.05
Parent Self-Awareness TOTAL		45.5	(5.0)	45.5	15	45.8	(8.1)	45.8	15	.02	.89	.06
Parenting Stress Index-Short Form												
Parent Distress	15	25.3	(7.8)	24.7	14	28.6	(10.5)	29.2	16	2.44	.13	-.58
Parent/Child Dysfun.	15	20.9	(6.3)	20.5	14	21.6	(6.3)	21.9	16	.51	.48	-.22
Difficult Child	16	25.9	(6.5)	26.3	15	30.7	(8.2)	30.2	16	2.49	.13	-.60

(see previous page for notes)

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Across reassessment, only one statistically significant benefit was reported for the high-intensity group. None were reported for the low-intensity group. At the 36-month assessment, mothers in the high-intensity group reported a statistically significantly lower amount of stress associated with difficult children. The result did not remain over time however and may be due to random fluctuation. Effect sizes indicate a possible benefit (i.e., lower stress scores) for the high-intensity group at the 24 and 36-month reassessments, but the 48-month reassessment showed a benefit for the low-intensity group. It should be noted that between the 24 and 36-month assessment the PSI was switched from the long form to the short form.

The FSS, FACES, and PSAS also failed to reach statistical significance at most of the reassessments. The FSS consistently favored the high-intensity group, but only reached statistical significance at the initial assessment. The average effect size surpassed one-third of a standard deviation (.34) across the reassessments and suggests that families in the high-intensity group did perceive themselves as receiving greater amounts of family support than those in the low-intensity group. This was one of the goals of the intervention and is consistent across the four years of the study.

The FACES was analyzed as two separate scales, family adaptability and family cohesion. Family adaptability started with an effect size of .46 but fell to .01 by the 24-month evaluation. The family cohesion scale indicated that families in the low-intensity groups were more cohesive, though not statistically significantly, through the 12-month assessment. At the 24-month assessment, the high-intensity group tended to be more cohesive. The measure was not administered as part of the 36 or 48-month evaluations.

The PSAS was administered at both the 36 and 48-month assessments. At neither time did it statistically favor either group.

Although there were few statistically significant differences between the intervention groups among the family measures across reassessments for the Columbus

Medically Fragile Study, the importance of the intervention cannot be answered at a group level. Parents likely know the interventions that will work for their family. If increased referrals and extensive medical follow-ups are perceived as important, then they are. Families who have children who are at risk for developing disabilities should be given a choice as to the relative benefits of one intervention over another. Families who are given a choice are likely to be the families obtaining the largest benefit from the intervention. Again, one blanket solution will probably fail to have the desired benefit for all families.

Subgroup Analyses

Rural service delivery. One variable which may have affected the efficacy of the intervention was the county where the individual families resided at the time of intervention. Franklin County encompasses the Columbus urban area. The families and infants who participated in the study resided in Franklin County or one of 18 rural counties in southeastern Ohio. The transition services provided to the high-intensity group may have been more valuable to the infants and families who live in rural areas. The project was based in Franklin county at Columbus Children's Hospital. As mentioned in the section on the rationale for the study, most of the improvements and advances in perinatal care have been concentrated in the tertiary care hospital and environment. Infants and families who live near the hospital have easier access to treatment and early intervention services that are focused on their needs. Those living in rural areas have limited access to early intervention services. Thus, the transition services provided to the high intensity group may have been more beneficial to the infants and families who live outside of Franklin county.

To determine whether there was a differential impact of treatment for infants in rural areas, all of the data for infants who resided outside Franklin County during the intervention were analyzed in a separate analysis. The rural high- and low-intensity groups living outside Franklin County were examined for pretest differences on demographic, medical, child, and family development variables. Significant differences were found for the number of hours the father worked and the Family Support Scale. The correlations between these variables and each reassessment were analyzed and covariates selected as appropriate. An ANCOVA was completed for all of the reassessment measures of child and family functioning with only the rural infants who were assigned to the high- and low-intensity interventions. The results show no statistically significant differences on most measures. The adaptive domain of the BDI at the 36 month reassessment showed the low-intensity rural children scoring statistically significantly higher than the high-intensity rural children. Of the family measures examined, only the 18 month reassessment FSS was statistically significant. It had a p-value of .03 and an effect size of .71 favoring the high-intensity group. The results for family and child functioning were very similar to the ANCOVA results presented for all of the families who participated.

Severity. A conclusion drawn in a recent review of the efficacy of early intervention was that one of the strongest predictors of developmental progress for infants and children is severity of impairment (Dunst, Snyder, & Mankinen, 1989). The level of severity may interact with early intervention services in such a way that differential effects result depending on whether the impairment is mild or severe. To examine whether interactions between severity and intervention occurred in this study, infants were placed into a severe or mild disability category based on their medical severity index at the initial assessment. As mentioned earlier in this report, the medical severity index was computed from nine variables which included degree of technology dependence, oxygen dependence, respiratory status, age at discharge, neurologic status, ultrasound/CT findings, head circumference, feeding status, and sensory impairment. A group by severity of medical condition (2 x 2) analysis of covariance was then conducted for all reassessments for Bayley, Vineland, Infanib, and BDI scores. The results of this analysis showed statistically significant interaction effects between medical severity and the intensity of the intervention for the children in the two treatment groups on the 6-month Bayley Mental Developmental Index. At the 6-month reassessment, infants in the high-intensity group with mild delays performed significantly (*p* = .005, ES = 1.2) better than infants in the low-intensity group with mild delays. In contrast, the severe low-intensity infants scored significantly higher than severe high-intensity group infants (p = .005, ES = -.79) on the Bayley Mental Developmental Index. However, this difference did not hold for any of the other child outcome measures at the other reassessments.

Summary

Treatment Verification

The treatment verification data confirmed that the intervention of the Columbus Medically Fragile Project was implemented as intended. The traditional, low-intensity intervention provided NICU referrals and follow-up. The transition team, high-intensity intervention provided home and center based visits, helped to develop and implement IFSPs, and helped to develop relationships between the families and local service providers and ensured that timely, appropriate services were actually provided. The treatment verification data also showed that the high-intensity transition team services were indeed more intensive. This was apparent by the number of direct services provided by the team and by the differential IFSP development at the 18-month reassessment. The two groups also differed in the number of additional service hours. The high-intensity infants received significantly more early intervention service hours at the 12- and 36-month reassessments than the infants in the low-intensity intervention. At the time of the 24 month reassessment, they were receiving 2½ times as many early intervention service hours as the low-intensity group and this trend continued through the 36-month assessment.

Overall, initial assessment comparisons indicated that randomization procedures resulted in well-matched groups. At enrollment, statistically significant differences were found on only one demographic measure, one medical characteristic and none of the infants' developmental measures. These results suggested that the groups were similar. However, no family measures were collected prior to the initiation of early intervention services.

It is apparent that the high-intensity families and their infants received more hours of service than the low-intensity families. The time was the result of both the transition team and local early intervention programs. The transition team services focused on helping parents access services and teaching them how to deal with medical and other developmental concerns. Some of the local early intervention services were home-based, some were center-based.

The direct intervention provided to transition team infants was greatest between the time of enrollment and the 6-month reassessments. The intervention ended by about 12 months post-discharge. However, infants in the high-intensity intervention were receiving five times more early intervention service hours in their local communities at that time. By the 36-month reassessment, children in the more-intensive group were still receiving more than twice the number of early intervention service hours than the less-intensive group subjects, although that difference was not statistically significant. These differences, which may be attributed to the transition team follow-up with local service providers, may have resulted in differences at later reassessments.

Child measures. Measures of child functioning across the reassessments showed few statistically significant differences between the high- and low-intensity groups. The Bayley and INFANIB, administered at the 6- and 18-month reassessment, did not show statistically significant differences; however, the mental processing subscale of the Bayley did have an effect size of .53 at the 6-month reassessment. This suggests an immediate cognitive benefit to the high-intensity group, although the results were negligible by the 18-month reassessment.

Analysis of the BDI total scores at each reassessment placed the sample, as a group, below the first percentile. While the means were low relative to the normative sample, children who scored in the upper range of the group showed age equivalent gains over time. No significant differences emerged for any scale of the BDI at any reassessment. The effect sizes were likewise generally negligible.

Results from the subscales of the Carey Infant Temperament Scale (ITQ) at the 6-month reassessment were also not statistically significant. The diagnostic clusters of the ITQ did show interesting differences however. Thirty-five percent of the mothers in the low-intensity group, compared to 16% of the mothers in the high-intensity group, responded to items that placed their infants in the "difficult" category. The high-intensity group generally perceived their infants as "intermediate high." Twenty-six percent of the high-intensity mothers perceived their infants as "slow-to-warm-up". This percentage compared to 24% of the mother's in the low-intensity group who rated their infant "intermediate low". The "easy" category was the one that was used the least, only 6% in the low-intensity group compared to 11% in the high-intensity group.

Starting at the 12-month reassessment parents were asked to rate their child's health. At the 24-month reassessment parents in the high-intensity group rated their children statistically significant higher than the low-intensity group. The difference faded for subsequent years, possibly because of the different samples. For the 36 and 48-month assessments parents in the low-intensity group rated their children's health as increasing while parents in the high-intensity group fluctuated, but never dropped much below the middle rating.

Other child measures provided similar results. The Vineland Adaptive Behavior Scales' social scale was statistically significant and favored the high-intensity group at the 18-month reassessment. The Preschool Pictorial Perceived Competence and

Social Acceptance Scale did not show any statistically significant differences between the groups. The results suggested the PPPCSAS may be inappropriate for these children.

Family measures. Whether or not the intervention had an effect on the families functioning was another primary concern of the current study. The FRS was used as a measure of the resources available to the family. As a contextual variable, the FRS showed statistically significant differences through the 36-month reassessment. As an outcome variable the FRS showed statistically significant differences between the high- and low-intensity groups at the 12- and 36-month assessments. Although not statistically significant at the initial assessment or the 6-, 18-, or 24-month reassessment, the results favored the high-intensity group through the 36-month assessment. The 48-month reassessment, however, provided results that were equivalent between the groups.

The PSI revealed one statistically significant benefit for the high-intensity group at the 36-month reassessment. The result did not remain over time however and may be due to random fluctuation. Effect sizes indicated a possible benefit (i.e. lower stress scores) for the high-intensity group at the 24- and 36-month reassessments, but the 48-month reassessment showed a benefit for the low-intensity group. It should be noted that between the 24- and 36-month reassessment the PSI was switched from the long form to the short form.

The FSS, FACES, and PSAS were also not statistically significant at most of the reassessments. The FSS consistently favored the high-intensity group, but only reached statistical significance at the initial assessment. The average effect size surpassed one-third of a standard deviation (.34) across the reassessments and suggests that families in the high-intensity group did perceive themselves as receiving greater amounts of family support than those in the low-intensity group. This was one of the goals of the intervention and is consistent across the four years of the study.

The FACES was analyzed as two separate scales, family adaptability and family cohesion. Family adaptability started with an effect size of .46 but fell to .01 by the 24-month evaluation. The family cohesion scale indicated that families in the low-intensity groups were more cohesive, though not statistically significantly, through the 12-month assessment. At the 24-month assessment, the high-intensity group tended to be more cohesive. The measure was not administered as part of the 36 or 48-month evaluations.

The PSAS was administered at both the 36 and 48-month assessments. At neither time did it statistically favor either group.

Additional Analysis. The subgroup analysis for rural infants provided no evidence that the high-intensity intervention benefitted infants and families living in rural areas more than the low-intensity services provided to rural infants and their families. The intervention services provided by the transition team were most numerous between enrollment and 6-months of age but decreased between 6- and 12-months of age. There is some evidence that mildly delayed infants had temporary, statistically significantly gains on the Bayley Mental Developmental Index at 12-months of age, but the 18-month Bayley Measure of Mental Development was not statistically significant. Furthermore, it was slightly negative for the mildly impaired high-intensity infants. Consequently, the 6-month reassessment difference must be interpreted with caution and may be a random fluctuation in the sample.

Conclusions

The results of the Columbus Medically Fragile Project suggest an idiosyncratic programming for low-birth weight, premature infants. The intensities of intervention analyzed in this study may not be the optimal amount for all children and their families. An individual approach may be more beneficial for the government, hospitals, professionals, families, and their children.

Evidence exists that suggest the high-intensity intervention was not cost-effective in the short term. The high-intensity intervention cost approximately $7,800 more than the low-intensity intervention. There is no evidence to date that suggests the intervention was cost-effective for child development. Nearly $6,000 of the difference in expenditures were related directly to the transition team services financed by federal grants; nearly $2,000 of the difference in the cost of services was from state and local expenditures on the Public Health Nursing and Early Intervention services. These costs must be weighed against the effects for families. It is important to keep in mind possible alternative uses of the $7,800 and whether or not these funds would have had a greater impact if allocated to different programming for these children and families or even to other programs for different families.

If the main benefit of the high-intensity intervention was to provide respite care for families (as measured by the time-availability scale of the FRS), the implications and costs of such services could be drastically reduced. Traditional respite care is less costly, given the number of service hours, than the early intervention services provided in this program. This raises the question of whether the same effects could be achieved at a lower cost by changing program services.

Through the 48-month reassessment though, few differences emerged between the children in the high- and low-intensity intervention groups. Outcome measures for the children did not show any consistent group differences. Despite the lack of statistically significant differences, interesting knowledge about the infants was gained. Children in the low-intensity group were more likely to be classified as difficult on the ITQ than children in the high-intensity group. It is conceivable that the intervention made a difference in the mother's perception of her infant, thereby theoretically increasing their positive interactions or increasing their optimistic outlook. Children scoring on the upper end (relative to this sample) of the BDI appear to be making gains on their peers while children who score at or below the mean stay relatively behind their same age peers. This observation warrants further attention.

The lack of differences on child measures may also say little about the intervention. While it appears that increased services did not directly impact child functioning as measured by these instruments, it did not hurt their development either. If the intervention had an affect in other areas -such as a decreased probability of needing further early intervention services- the increase in early services may be worth the cost. From a parents perspective, if they think it will help, and it is unlikely to hinder development, let them choose if the intervention is worth the extra time and effort. Chances are, they know what will make a difference more than a stranger who interacts with the family for a very brief period. These results call for a more individual approach to early intervention, not a program for the masses where one amount is the best for everybody. An intervention of this sort may increase the parent's perception of their infant and have an indirect impact as the children mature. It is also possible that differences in outcome will appear later as the children grow older. This could be particularly true as the children enter public school and teacher evaluations and school outcome data become available.

Interpretation of the results for family functioning is made more difficult for two reasons. First, the one study of early intervention with medically fragile infants identified in the literature review did not incorporate measures of family outcome. Second, no family measures were collected prior to initiation of the early intervention services. If there were pretreatment differences on these measures, it is not possible to control for such differences.

The few significant differences between the intervention groups among the family measures across reassessments for the Columbus Medically Fragile Study highlight the importance of family-based, individual interventions. Parents likely know the interventions that will work for their family. If increased referrals and extensive medical follow-ups are perceived as important, then they are. Families who have children who are at risk for developing disabilities should be given a choice as to the relative benefits of one intervention over another. Families who are given a choice are likely to be the families obtaining the largest benefit from the intervention. Again, one blanket solution will probably fail to have the desired benefit for all families.

The Infant Health and Development Project did not find statistically significant differences between the intervention groups until the children were 24 months adjusted age. The greater amount of early intervention services levels to children in the high-intensity group at the 36-month reassessment is evidence that differences in service continued and may be accompanied by measurable differences in child and/or family outcomes as the longitudinal follow-up continues.

DES MOINES PUBLIC SCHOOLS

Project #8

COMPARISON: Children with Mild to Severe Disabilities -- Classroom-based intervention plus parent involvement vs. classroom-based intervention only

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LOCATION: Des Moines, Iowa

DATE OF REPORT: October 1, 1994

Rationale for the Study

Parent involvement is often considered an important part of early intervention programs for young children with disabilities. This belief is so strong that it has been incorporated into the law mandating services for these young children (Individuals with Disabilities Education Act [IDEA], P.L. 102-119). Unfortunately, the empirical support for this belief is not as clear as one might assume based on the IDEA mandate (White, Taylor, & Moss, 1992). Concerns have been raised regarding the efficacy of parent involvement in general and, specifically, to what types of parent involvement are most beneficial to children and families (Casto & Mastropieri, 1986; White et al., 1992). This study examined the effects of adding one particular type of parent involvement to an existing classroom-based early intervention program for children with disabilities. The type of parent involvement program investigated as a part of this study included weekly parent meetings that focused on: a) training parents to work with their children on skills/behaviors, b) educating parents on various topics (such as legal rights, child assessment, child development, etc.), and c) providing support to parents in the form of a parent group and assistance in accessing available resources.

Review of Related Research

The issue of parent involvement in early intervention has been a subject of many reviews of literature (Bronfenbrenner, 1974; Comptroller General, 1979; Datta, 1971; Floren & Dokekci, 1983; Karnes & Lee, 1978; Lazar & Darlington, 1982). These reviews have almost unequivocally concluded that early intervention programs that involve parents will be more effective than those that do not. In examining the research studies cited by these reviews, White et al. (1992) found that the individual results did not support the conclusions of the reviews. White et al. raised further concerns by concluding that the research cited in these reviews had focused only on children who were disadvantaged, was of relatively poor methodological quality, and had defined parental involvement primarily as using the parent as a supplemental therapist.

Extending their analysis, White et al. (1992) raised the question, "What are the effects of parent involvement programs on young children with disabilities and on their families?" Using data that had been prepared for a meta-analysis of early intervention (Casto & Mastropieri, 1986), White et al. compared effect sizes from 89 studies that used children with disabilities as subjects. All of these studies included some type of parent involvement. These studies were divided into two categories for analysis: studies that included extensive/moderate parent involvement and those that included little/no parent involvement. The results of this analysis were equivocal with respect to degree of parent involvement (i.e., more parent involvement was not necessarily better). It should be made clear that not all of these studies were examining parent involvement as an intervention strategy, only that these studies included parent involvement and the parent involvement could be coded.

Studies (from the above analyses) that specifically investigated the effect of parental involvement in early intervention for children with disabilities were individually examined. Unfortunately, the majority of these were indirect comparisons, confounded by differences in the interventions being compared. Only five studies were found, other than those being conducted by EIRI, that directly compared a parent involvement intervention with a no parent involvement intervention (Barnett, Escobar, & Ravsten, 1988; Henry, 1977; Miller, 1981; Minor, Minor, & Williams, 1983; Scherzer, Mike, & Ilson, 1976). In all these studies, parents were trained to provide some type of therapy. Although these studies report positive effects of parent involvement, research methodology problems existed.

The review by White et al. makes it clear that current beliefs regarding parent involvement in early intervention are not based on a clear research foundation. However, it is a moot point to argue whether parents should be involved, because parent involvement is required by law. Rather, the questions that need to be asked are: "What is the best way to involve parents?" and "What types of benefits are derived from different types of parent involvement?" To begin this type of analysis, different types of parent involvement must be defined and potential benefits elaborated.

Peterson and Cooper (1989) delineated six aspects of parent involvement programs: (1) information provision, (2) professional partnership, (3) support network, (4) training, (5) respite care, and (6) informal contact with staff. For each aspect of parent involvement, a different outcome may be expected. However, Gatling and White (1987), in a review of 172 parent involvement studies, found that over 80% of studies focus on parent training (i.e., training parents as intervenors or therapists for their children) as either the sole or major focus of the parent involvement program. This focus requires data on child outcomes to gauge effectiveness.

However, as the above review indicates, available data currently does not allow for empirically based decisions.

The possibility also exists that these six aspects of parent involvement overlap and that even though one aspect may be emphasized, positive outcomes may be realized in other areas. From an ecological or systems perspective (Bronfenbrenner, 1979; Dunst, 1986), parent involvement activities may affect aspects of family functioning that may impact on the child's later development and functioning (i.e., Blacher, 1984; Kaiser & Fox, 1986), even though immediate child effects may not occur. Historically, research on the effects of involving parents in early intervention programs has not typically included the assessment of family functioning or other areas For example, none of the research cited by White et al. (1992) contained information on family impacts.

Recent research (Shonkoff, Hauser-Cram, Krauss, & Upshur, 1992) has raised the question of whether parent groups negatively impact some family outcomes. Results from Shonkoff and colleagues (1992) indicated that participation in parent groups was positively associated with social support outcomes but also increased strains within the family. The focus of the parent groups was not described. These findings reinforce the suggestion that measures of family outcomes need to be included in parent involvement research, especially while attending to the content of the group activities.

The economic implications of involving parents in early interventions must also be considered, especially given the fact that parent involvement is required by IDEA. Several recent reviews of the literature revealed that the quality of economic studies in early intervention is questionable (Barnett & Escobar, 1987, 1988, 1990). Cost-effectiveness information on parent involvement programs, information which is not currently available, is needed to help bridge the gap between policy and research.

These issues regarding parental involvement come at a time of ever increasing discussion of what are the best ways to involve parents in early intervention activities (e.g., Dunst & Trivette, 1990; Simeonsson & Bailey, 1990). These issues of how to involve parents are accompanied by recent reformulations of theories related to families. For example, Krauss and Jacobs (1990) identify a number of theories that could impact on the practice of early intervention--family sociology theory, family systems theory, family stress theory, and family life cycle theory (see Krauss and Jacobs for greater detail on these theories). All of these theories support the involvement of parents in early intervention and suggest that appropriate involvement will positively impact families and children.

What typically occurs in practice is that interventionists tend to offer general services that are not necessarily grounded in a specific theory (Krauss & Jacobs, 1990). In fact, the recommended practices for family participation in intervention by the Division for Early Childhood (DEC), of the Council for Exceptional Children, do not make mention of any specific theory but provide more functional guidelines for program activities (DEC, 1993). Regardless of the theoretical versus practice issues, the use of parent groups as part of an early intervention program for both infant/toddlers and preschool-age children with disabilities is common practice (Mahoney & O'Sullivan, 1990; Shonkoff et al., 1992). The use of group formats for parents most likely continues because a variety of individual parent needs can be met (similar to meeting individualized child goals in a classroom setting), groups make effective use of limited early intervention personnel, and group programs are frequently viewed as less costly than other options. Given our lack of knowledge about the outcomes of parent groups, combined with their frequent use in practice, it is critical that research occurs that examines different types of parent groups (documenting the focus of the groups and the types of parents involved), and the outcomes which result.

Overview of Study

The purpose of this study was to use a randomized experimental design to investigate the effects and costs of adding one type of parent involvement program, the most common type of program, to an existing classroom-based early intervention program. Since all of the children participated in the same classroom-based early intervention program, but only half of the children had parents who participated in the Parent Involvement program, differences at the conclusion of the study in measures of child and family functioning can be attributed to the presence of or lack of the parent involvement component.

The curriculum for the parent involvement component (Parents Involved in Education [PIE]; Pezzino & Lauritzen, 1986) was structured to focus on those aspects that had been used most frequently in past research. These aspects were training parents as an intervenor/therapist for their child, providing parents with information, and providing a parent support focus. Interventions similar to the PIE are commonly offered as an addition to an established early intervention program (Gatling & White, 1987; Mahoney & O'Sullivan, 1990). The present study approached the question of parent involvement by comparing PIE as a supplement to a classroom-based intervention program versus effects of the classroom-based program without PIE.

The present study was unique in a number of ways. First, information was collected on child and family outcome measures; impacts on families have not typically been assessed in previous research but may be an important outcome. Second, this study was longitudinal and allowed assessment of outcomes that occurred after the child left the early intervention system. Third, this study included treatment verification measures and measures of contextual variables to confirm that measured effects were due to intervention and not other factors. Fourth, a cost-effectiveness analysis was conducted to investigate the relative efficiency of the programs being compared.

Based on the common assumptions of the impact of parent involvement in early intervention as summarized in the White et al. (1992) literature review, it was hypothesized that adding this parent involvement program would result in better child outcomes and be more cost-effective. It was also hypothesized that the addition of this parent involvement program would result in better family outcomes especially in the areas of stress and perceptions of social support. Finally, a secondary hypothesis was that the addition of this parent involvement program would improve the parent/professional partnership which would then enhance future school interactions.

In addition, this study investigated the issue of whether parent-attended meetings with a training (PIE I) or support-oriented (PIE II) focus were more efficacious. Parent support as an appropriate focus for parent intervention activities is receiving attention and interest in recent literature (e.g., Dunst, 1986; Dunst et al., 1988; Hanline & Knowlton, 1988; Mahoney & O'Sullivan, 1990; Shonkoff et al., 1992; Zeitlin & Williamson, 1988). However, no comparative information exists on the effect of a parent support intervention on children and families. In order to provide some preliminary information on parent support issues, parents who participated in PIE and whose children remained in the early intervention program for a second year participated in an intervention focused on parent support (PIE II; Durbala & Hollinger, 1988). Although the addition of the parent support component (PIE II) may be affected by the fact that these parents received the PIE I intervention, comparisons with cohorts receiving only PIE I and then receiving only classroom-based intervention should provide information regarding support as a focus of parent intervention.

Methods

Subjects participating in this study were served through the Des Moines Public School System. The Des Moines public schools serves all children with disabilities in the Des Moines School District from birth through 6 years of age. (The State of

Iowa has had a law mandating a free and appropriate public education to children with disabilities from birth through age 5 since 1975.) At the time this study was implemented, children with disabilities in the Des Moines Public Schools ages 0-2 were typically served through home-based intervention programs, while preschoolers with disabilities, ages 3-6, typically received intervention services in classroom-based settings. The general philosophy of the Des Moines Public Schools was (and is) to provide high-quality educational services that maximized each child's individual potential. Programs for children were developed based on comprehensive individual assessments conducted by members of a multidisciplinary team. Parents were required to participate in the development of Individualized Education Plans.

Subjects participating in this study were served at the Phillips, Findley, and Perkins schools. This represents three of the many neighborhood schools in the Des Moines Public School System in which preschoolers with disabilities were served. These schools were selected because teachers and professional support staff (psychologists, speech therapists, occupational therapists, social workers) who work in these schools were interested in conducting this research study in collaboration with EIRI. The liaison at Des Moines responsible for coordinating day-to-day activities of the research study was a school psychologist employed by the school district who had responsibilities at each of the three participating locations.

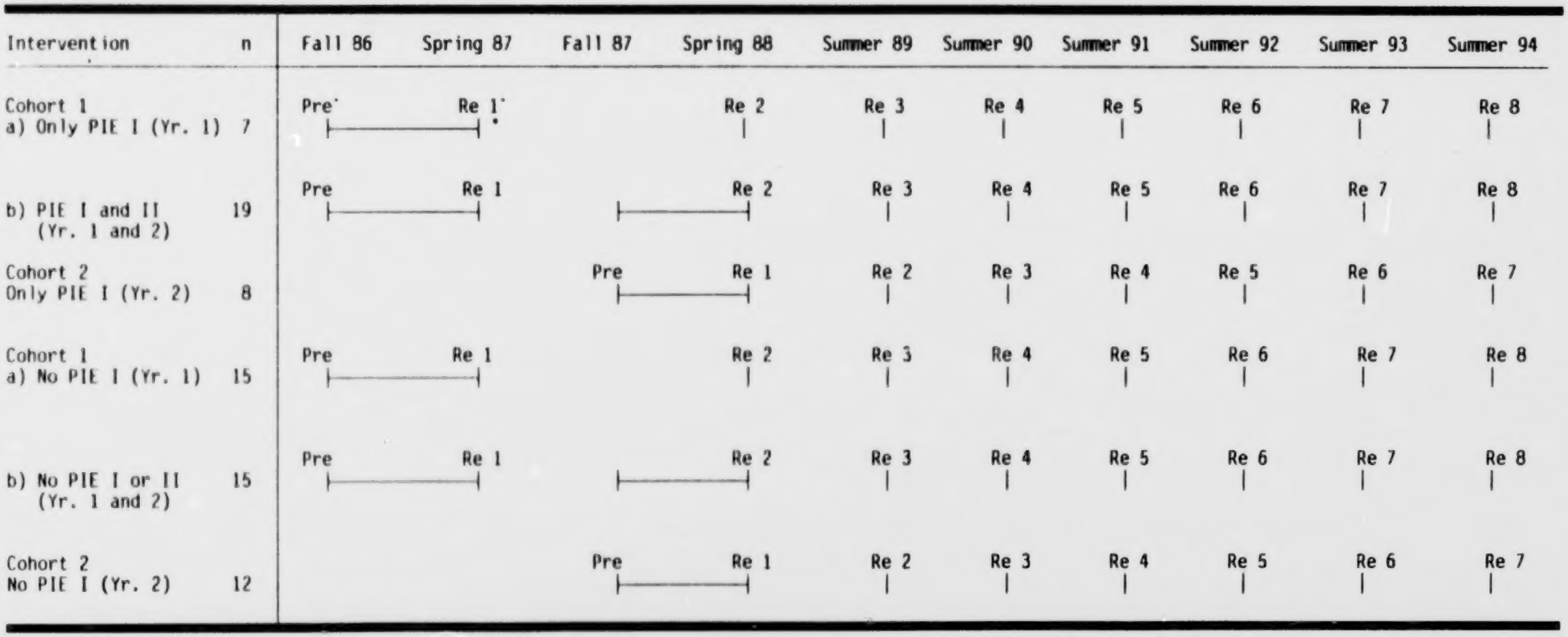
Subjects. The subjects were 76 children (42 control, 34 experimental), 55 of whom were male. These subjects ranged in age from 35 to 72 months at the time they began participation in the research. All subjects were identified as being disabled. Approximately 75% of these subjects demonstrated a developmental delay of unknown etiology characterized primarily by cognitive and language impairments. The degree of disability for all subjects ranged from severe to mild. The majority of subjects were mild to moderately delayed, 55% had developmental quotients (based on the total score of the Battelle Developmental Inventory (BDI) below 65.

These subjects can be divided into two distinct cohorts (see Figure 8.1). Cohort #1 consisted of those subjects enrolled during the 1986/87 academic year. There were 56 subjects in this cohort (30 control, 26 experimental), 40 of whom were male. The subjects ranged in age from 35 to 72 months at the time they became involved in the research. Cohort #2 consisted of those subjects newly enrolled during the 1987/88 academic year. There were 20 subjects in this cohort (12 control, 8 experimental), 15 of whom were male. Age of subjects in this cohort ranged from 36 to 72 months when intervention began. A subgroup of Cohort #1 consisted of those subjects who participated in the research for 2 years. This subgroup consisted of 34 subjects (15 control, 19 experimental), 22 of whom were male. These subjects ranged in age from 35 to 61 months when their participation began.

This report will examine data collected through Summer '93 and some of the data collected during Summer '94; this represents data on all subjects through Reassessment #7. Summer '94 data have been collected on Cohort #1 subjects for Reassessment #8 but these are not yet available for analyses.

Reassessment #1 included all subjects from the 1986/87 and subjects newly enrolled from the 1987/88 academic years (see Figure 8.1). All subjects had received one year of intervention at Reassessment #1.

Reassessment #2 included subjects who continued in the early intervention program (15 control, 19 experimental) and subjects who "graduated" to school-age programs (27 control, 15 experimental). Subjects who continued in the program are those who were referred to earlier as the subgroup of the first cohort (Cohort #1b in Figure 8.1). The degree of disability for these subgroup subjects varied, and 60% had developmental quotients (based on the BDI Total Score) below 65. Approximately 70% of these subjects demonstrated a developmental delay of unknown etiology characterized primarily by cognitive impairments.



Intervention	n	Fall 86	Spring 87	Fall 87	Spring 88	Summer 89	Summer 90	Summer 91	Summer 92	Summer 93	Summer 94
Cohort 1 a) Only PIE I (Yr. 1)	7	Pre*	Re 1*		Re 2	Re 3	Re 4	Re 5	Re 6	Re 7	Re 8
b) PIE I and II (Yr. 1 and 2)	19	Pre	Re 1		Re 2	Re 3	Re 4	Re 5	Re 6	Re 7	Re 8
Cohort 2 Only PIE I (Yr. 2)	8			Pre	Re 1	Re 2	Re 3	Re 4	Re 5	Re 6	Re 7
Cohort 1 a) No PIE I (Yr. 1)	15	Pre	Re 1		Re 2	Re 3	Re 4	Re 5	Re 6	Re 7	Re 8
b) No PIE I or II (Yr. 1 and 2)	15	Pre	Re 1		Re 2	Re 3	Re 4	Re 5	Re 6	Re 7	Re 8
Cohort 2 No PIE I (Yr. 2)	12			Pre	Re 1	Re 2	Re 3	Re 4	Re 5	Re 6	Re 7

Figure 8.1: Group Assignment Information and Posttesting Schedule by Academic Year for the Des Moines Study

*Pre = Pretest

*Re(#) = Reassessment (number indicating which Reassessment)

•Lines represent intervention periods

At Reassessment #3, all subjects had "graduated" from the intervention program as defined by the research project, and approximately 75% of the subjects were in elementary school programs. The remaining subjects stayed in the preschool intervention program. No parent involvement activities, other than those described later in the Classroom-Only program, were provided to those who remained in preschool intervention.

Reassessments #4 through #7 include information for Cohort #1 and Cohort #2 children. All children were in elementary school programs at these reassessments.

Recruitment. Parents of children in participating schools who were scheduled for preschool placement at the beginning of the academic year (1986/87 and 1987/88) were considered for inclusion in the study if the following criteria were met: (a) One parent was not working or the parent could guarantee time off from work (this was done to help ensure parents had time available to attend parent meetings); and (b) the child was not profoundly delayed (preschool program staff were of the opinion that the needs of parents of these children would not be best met through the PIE). Parents of children at the participating schools who met these criteria were individually approached by preschool program staff. Preschool staff described the research and detailed parent and staff requirements. Placement in study group by random assignment procedures was described. If interested, parents returned an informed consent letter that clarified their requirements for, and potential benefits of, participation, and stated that assignment to groups would be randomly determined. Approximately 95% of the parents who were approached regarding the research agreed to participate.

Assignment to groups. Subjects who met the criteria for inclusion were randomly assigned to one of two treatment groups prior to the initiation of treatment, either to a group in which parents received the PIE (Classroom + PIE) or to a group in which parents received no additional involvement other than what was provided to all parents through the classroom-based program (Classroom Only). Both groups continued to receive the same level of classroom-based services that were previously available through the school's program for preschoolers with disabilities.

To increase the probability of having comparable groups, subjects were randomly assigned to groups after being stratified as follows. Subjects were categorized according to chronological age (35-42 months, 43-54 months, and over 55 months) and level of parent motivation (either "high" or "low") as perceived by each child's teacher. Categorizing subjects in this way resulted in subjects falling into one of five mutually exclusive categories. Within each of the categories, subjects were rank ordered from low to high based on their scores on the CAPER (Continuum of Assessment Programming, Evaluation, and Resources; Carran, 1983). The CAPER, a teacher-administered test of developmental functioning, had been administered by school personnel at an earlier date.

After subjects were categorized, they were alternately assigned to one of the two conditions. Group determination of the first-listed subject (the subject with the lowest CAPER score) in each age by motivation category was accomplished randomly. Additional subjects within the same category were then alternately assigned to groups based on randomly predetermined sequences. Subjects that participated for 2 years remained in the originally assigned group.

Demographic characteristics. Subjects for this study represented a fairly homogenous sample (see Table 8.1). The majority of subjects were Caucasian males with one sibling. The parents of the subjects were generally in their late 20s or early 30s and had a high school education. The majority of subjects were living in two-parent families; and traditional, in the sense that the mother was the primary caregiver. English was the primary language for all families. Based on family income, the typical family would be considered lower to middle class.

Table 8.1 presents data for subjects who received one year of intervention by group on demographic characteristics. Some discrepancies between Classroom-Only and

Table 8.1

Comparability of Groups on Demographic Characteristics for Des Moines Parent Involvement Study

	Reassessment #1								Reassessment #2							
	Classroom Only			Classroom + PIE					Classroom Only			Classroom + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES
• Age of child in months at pretest	53.0	(11.7)	42	52.3	(11.9)	34	.82	-.06	52.0	(11.5)	37	52.0	(11.8)	33	.93	.00
• Age of mother in years at pretest	28.2	(5.6)	40	30.8	(4.8)	33	.03	.46	28.0	(5.9)	35	31.0	(4.8)	32	.05	.51
• Age of father in years at pretest	30.3	(6.8)	33	33.1	(6.1)	27	.12	.41	31.0	(7.0)	28	33.0	(6.2)	26	.24	.29
• Percent Male[a]	71.4		42	73.5		34	.84	.05	68.0		37	76.0		33	.46	.22
• Years of Education for Mother	11.4	(2.2)	42	12.7	(1.9)	34	.01	.59	11.7	(1.9)	37	12.7	(2.0)	33	.04	.53
• Years of Education for Father	11.8	(2.2)	32	12.8	(2.6)	31	.13	.45	12.0	(2.3)	27	12.7	(2.7)	30	.25	.30
• Percent with both parents[a] living at home	66.7		42	70.6		34	.72	.10	65.0		37	70.0		33	.67	.12
• Percent of children who[a] are Caucasian	80.5		41	91.2		34	.19	.41	81.0		36	91.0		33	.23	.40
• Hours per week mother employed	6.6	(12.0)	41	5.1	(11.0)	34	.69	-.13	5.0	(10.2)	36	5.3	(11.2)	33	.91	.03
• Hours per week father employed	32.1	(22.6)	27	33.3	(22.3)	29	.84	.05	34.2	(22.4)	23	33.1	(22.6)	28	.86	-.05
• Percent of mothers[a] employed as technical/ managerial or above	5.0		40	2.9		34	.66	-.13	6.0		35	3.0		33	.60	-.18
• Percent of fathers[a] employed as technical/ managerial or above	10.3		29	37.9		29	.01	.84	13.0		24	39.0		28	.03	.77
• Total household income	$14,307	($15,496)	39	$21,632	($18,323)	34	.07	.47	$14,309	($15,840)	34	$22,091	($18,408)	33	.07	.49
• Percent with mother as[a] primary caregiver	95.0		40	97.1		34	.66	.13	94.0		35	97.0		33	.60	.18
• Percent of children in daycare	35.9		39	35.3		34	.96	-.01	32.0		34	36.0		33	.73	.10
• Number of siblings	1.3	(0.8)	41	1.5	(0.8)	34	.42	.25	1.3	(0.8)	36	1.5	(0.8)	33	.17	.25
• Percent with English[a] as primary language	100		41	100		34	.99	.00	100		36	100		33	.99	.00

(continued)

[a] Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "0"

$$ES = \frac{\bar{x}\ (\text{Classroom + PIE}) - \bar{x}\ (\text{Classroom only})}{SD\ (\text{Classroom Only})}$$

ESs for percentage values are based on a probit transformation. The sign of the effect size only indicates direction of result, no value judgments are intended.

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Table 8.1 (continued)

Comparability of Groups on Demographic Characteristics for Des Moines Parent Involvement Study

	Reassessment #3								Reassessment #4							
	Classroom Only			Classroom + PIE					Classroom Only			Classroom + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES
• Age of child in months at pretest	52.0	(11.9)	37	52.0	(11.3)	31	.90	.00	52.2	(12.0)	37	52.4	(12.0)	34	.96	.02
• Age of mother in years at pretest	28.0	(5.8)	35	31.0	(4.9)	30	.06	.52	28.1	(5.8)	35	30.8	(4.8)	33	.04	.47
• Age of father in years at pretest	31.0	(7.0)	28	32.0	(4.8)	24	.36	.14	30.8	(7.0)	28	33.1	(6.1)	27	.21	.33
• Percent Male	68.0		37	74		31	.56	.17	67.6		37	73.5		34	.60	.16
• Years of Education for Mother	11.6	(2.0)	37	12.7	(1.8)	31	.02	.55	11.6	(2.0)	37	12.7	(1.9)	34	.02	.55
• Years of Education for Father	11.8	(2.4)	27	12.8	(2.5)	28	.13	.42	11.8	(2.4)	27	12.8	(2.6)	31	.16	.42
• Percent with both parents living at home	70.0		37	68.0		31	.83	-.07	70.3		37	70.6		34	.98	.01
• Percent of children who are Caucasian	83.0		36	90.0		31	.41	.27	83.3		36	91.2		34	.33	.32
• Hours per week mother employed	5.9	(11.3)	36	5.6	(11.4)	31	.91	-.03	5.9	(11.3)	36	5.1	(11.0)	34	.76	-.07
• Hours per week father employed	32.8	(22.9)	24	34.1	(22.5)	26	.84	.06	32.8	(22.9)	24	33.3	(22.3)	29	.93	.02
• Percent of mothers employed as technical/ managerial or above	6.0		35	3.0		31	.63	-.15	5.7		35	2.9		34	.56	-.20
• Percent of fathers employed as technical/ managerial or above	13.0		24	38.0		26	.04	.75	12.5		24	37.9		29	.18	.73
• Total household income	$15,309	($15,916)	34	$21,016	($15,942)	31	.15	.36	$15,309	($15,916)	34	$21,632	($18,323)	34	.13	.40
• Percent with mother as primary caregiver	94.0		35	97.0		31	.63	.15	94.4		35	97.1		34	.58	.20
• Percent of children in daycare	37.0		35	32.0		31	.68	-.12	37.1		35	35.3		34	.88	-.05
• Number of siblings	1.4	(0.8)	36	1.6	(0.8)	31	.27	.25	1.4	(.8)	36	1.5	(.8)	34	.58	.13
• Percent with English as primary language	100		36	100		31	.99	.00	100		36	100		34	.99	.00

(see notes on previous page)

Table 8.1 (continued)

Comparability of Groups on Demographic Characteristics for Des Moines Parent Involvement Study

	Reassessment #5							
	Classroom-Only			Classroom + PIE				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Age of child in months at pretest	52.3	(11.6)	38	52.6	(12.0)	33	.92	.19
• Age of mother in years at pretest	28.0	(5.8)	36	30.5	(4.6)	32	.05	.43
• Age of father in years at pretest	30.7	(6.9)	29	33.1	(6.1)	27	.18	.35
• Percent Male'	68.4		38	72.7		33	.70	-.08
• Years of Education Mother	11.7	(1.9)	38	12.7	(2.0)	33	.04	.53
• Years of Education Father	12.0	(2.2)	28	12.8	(2.6)	31	.21	.36
• % with both parents' living at home	65.7		38	72.7		33	.54	-.14
• % of children who are' Caucasian	78.4		37	90.9		33	.15	-.31
• Hours per week mother employed	5.8	(11.2)	37	5.3	(11.2)	33	.85	-.04
• Hours per week father employed	34.2	(22.3)	23	33.3	(22.3)	29	.89	-.04
• % of mothers employed' as technical/managerial or above	6.6		36	3.0		33	.61	.09
• % of fathers employed' as technical/managerial or above	12.0		25	37.9		29	.03	-.56
• Total household income	$14,828	($15,905)	35	$20,015	($15,954)	33	.18	.33
• % with mother as' primary caregiver	94.4		36	97.0		33	.61	-.09
• % of children in' daycare	37.1		35	33.3		33	.75	.07
• Number of siblings	1.3	(.8)	37	1.5	(.8)	33	.33	.25
• % with English as' as primary language	100		37	100		33	.99	.00

(continued)

' Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "0."

$$ES = \frac{\bar{x}\text{ (Classroom + PIE)} - \bar{x}\text{ (Classroom Only)}}{\text{SD (Classroom Only)}}$$

ESs for percentage values are based on a probit transformation. The sign of the effect size only indicates direction of result, no value judgments are intended.

Table 8.1 (continued)

Comparability of Groups on Demographic Characteristics for Des Moines Parent Involvement Study

	Reassessment #6							
	Classroom-Only			Classroom + PIE				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Age of child in months at at pretest	52.1	(11.6)	37	52.7	(12.2)	32	.82	.05
• Age of mother at pretest	27.8	(5.6)	37	30.7	(4.5)	31	.02	.52
• Age of father at pretest	30.7	(6.9)	29	33.3	(6.1)	26	.15	.38
• Percent male	67.6		37	75.0		32	.54	.15
• Years of education mother	11.7	(1.9)	37	12.7	(2.0)	32	.04	.53
• Years of education father	12.0	(2.2)	28	12.8	(2.7)	30	.20	.36
• Percent with both parents living at home	67.6		37	71.9		32	.72	.08
• Percent of children who are Caucasian	78.4		37	87.5		32	.38	.21
• Percent of mothers employed as technical/ managerial or above	15.6		37	12.5		32	.72	-.09
• Percent of fathers employed as technical/ managerial or above	14.3		37	39.1		28	.04	.56
• Total household income	$15,191.	(15,997)	34	$19,937.	(16,203)	32	.24	.30
• Number of siblings	1.3	(0.8)	38	1.5	(.84)	32	.33	.25
• Percent with mother as primary caregiver	94.3		37	96.9		32	.76	.07
• Hours per week father employed	34.2	(22.3)	23	33.1	(22.6)	28	.86	-.05
• Hours per week mother employed	5.9	(11.3)	36	4.8	(11.0)	32	.66	-.10
• Percent with mother as primary caregiver	94.3		35	96.9		32	.72	.09
• Percent of children in daycare	41.2		34	34.4		32	.94	-.02

(see notes on previous page)

(continued)

Table 8.1 (continued)
Comparability of Groups on Demographic Characteristics for Des Moines Parent Involvement Study

Variable	Classroom-Only			Classroom + PIE			p Value	ES
	x	(SD)	n	x	(SD)	n		
Reassessment #7								
• Age of child in months at pretest	52.1	(11.6)	37	52.6	(12.0)	33	.85	.04
• Age of mother at pretest	27.8	(5.6)	37	30.5	(4.5)	33	.03	.48
• Age of father at pretest	30.7	(6.9)	29	33.1	(6.1)	27	.18	.35
• Percent male	67.6		37	72.7		33	.67	.10
• Years of education mother	11.7	(1.9)	37	12.7	(2.0)	33	.04	.53
• Years of education father	12.0	(2.2)	28	12.8	(2.7)	31	.20	.36
• Percent with both parents living at home	67.6		37	71.9		33	.67	.10
• Percent of children who are caucasian	78.4		37	87.9		33	.34	.22
• Percent of mothers employed as technical/managerial or above	15.6		37	25.0		33	.43	.19
• Percent of fathers employed as technical/managerial or above	14.3		37	45.4		33	.00	.69
• Total household income	$15,191.	(15,997)	34	$20,015.	(15,954)	33	.22	.30
• Number of siblings	1.3	(0.8)	38	1.5	(.83)	33	.36	.25
• Percent with mother as primary caregiver	94.3		37	97.0		33	.74	.08
• Hours per week father employed	34.2	(22.3)	23	32.8	(22.5)	28	.82	-.06
• Hours per week mother employed	5.9	(11.3)	36	5.4	(11.3)	32	.85	-.04
• Percent with mother as primary caregiver	94.3		35	96.9		32	.72	.09
• Percent of children in daycare	41.2		34	34.4		32	.94	-.02

Classroom + PIE groups are indicated. Mothers of subjects in the Classroom + PIE group tended to be older than mothers of subjects in the Classroom-Only group, and they also had higher levels of education. Fathers of Classroom + PIE subjects were much more likely to hold occupations placing them in higher SES categories. In addition, household income for families of subjects in the Classroom + PIE group tended to be higher than that for Classroom-Only subjects' families. Thus, in spite of the random assignment procedures, there was a slight bias in demographic characteristics favoring the Classroom + PIE group. Variables where such discrepancies occurred were considered as covariates in later analyses.

On measures that present demographic information on fathers, data are presented from a smaller "n" than many other variables. This can be partly attributed to data collection methods. Mothers were the primary providers of demographic and family functioning measures. In the majority of cases where "father data" was not obtained, it was not obtained from families where the father was not living at home. Table 8.1 also presents pretest demographic data on subjects who received Reassessments #2-#7, because the number of subjects at each reassessment differs slightly; this will be discussed below. Differences between groups noted earlier generally continued from reassessment to reassessment, suggesting a slight bias, based on demographic characteristics, in favor of the Classroom + PIE group.

Information on child grade placement is presented in Table 8.2. This table presents grade placement information from the time subjects left intervention (1987/88) until subjects were no longer in the preschool program (1990-91). Information is presented by cohort (see Figure 8.1). Longitudinal educational information is presented in a later section.

Table 8.2

Child Grade Placement* for Each Academic Year by Cohort**

	Year	87/88			88/89			89/90			90/91		
Grade	Cohort**	1a	1b	2	1a	1b	2	1a	1b	2	1a	1b	2
• Preschool		2▴	32^	20^	--	13	11	--	2	2	--	--	--
• Kindergarten		15	--	--	3	18	9	--	14	6	--	3	9
• First$		--	--	--	14	1	--	3	15	5	--	14	2
• Second		--	--	--	--	--	--	14	1	9	3	14	9
• Third		--	--	--	--	--	--	--	--	--	14	1	--

* Data obtained on 69 subjects at end of 1990/91 school year

** Cohort 1a = intervention during 1986/87; 1b = intervention 1986/87 and 1987/88, 2 = intervention 1987/88

^ These children in intervention

▴ These children not in school district preschool program

$ Children in ungraded placements were placed in grade based on their age and transition from intervention program for this table

Attrition. Eighty-six subjects were originally assigned to one of the groups. Of those, 76 subjects completed one year of intervention. All 10 subjects who did not complete one year of intervention were in the Classroom + PIE (experimental) group (Cohort #1a in Figure 8.1). For all 10 cases, withdrawal from the study was based on parent request to be removed from intervention.

At Reassessment #2, no attrition occurred with those subjects enrolled in intervention for two consecutive years or from Cohort #2 subjects. Of those subjects who "graduated" into the school-age program, six were lost to attrition during Reassessment #2. Five were Classroom-Only subjects, and one was a Classroom + PIE subject. In the Classroom-Only group, one family chose to discontinue participation, one family had moved, one child had recently been institutionalized and permission to test was not obtained, and the parents of two children refused testing at. In the Classroom + PIE group, the parent of one child refused testing at.

Eight subjects were lost to attrition at Reassessment #3 (total n = 68). Five of these subjects were from the Classroom-Only group, and three were from the Classroom + PIE group. The reasons for not testing the Classroom-Only subjects were the same as at Reassessment #2. In the Classroom + PIE group, the parents of two children refused testing, and one child could not be located. Once again, none of the Cohort #2 subjects were lost to attrition.

At Reassessment #4, 71 subjects were tested. Only 5 children from Cohort #1 were unavailable for testing. All these were Classroom-Only subjects and were the same five that had not been tested during past years. All Cohort #2 subjects were tested.

At Reassessment #5, 71 subjects were tested. Five children were unavailable for testing. Four of these children were Classroom-Only subjects, one was a Classroom + PIE subject. Two of the five Classroom-Only subjects who had not been tested at recent reassessments agreed to participate, but one (previously participating) Classroom-Only subject's family refused testing. One child in the Classroom-Only group was in foster care and permission to test could not be obtained. The parents of the Classroom + PIE child refused testing. All Cohort #2 subjects were tested.

At Reassessment #6, 69 subjects were tested. Of the seven children not assessed, four were the Classroom-Only subjects who were not assessed at Reassessment #5. Two more children, beyond Reassessment #5, were lost in the Classroom + PIE group. One child's parent refused testing, the other child was in foster care and permission to test was not obtained.

At Reassessment #7, 69 subjects were tested. Five Classroom-Only subjects were not tested. These were the four not tested in previous years and one subject who could not be located. Two Classroom + PIE subjects were not tested. One was the subject whose parents refused testing and one was a foster care child on whom permission to test was not obtained.

Attrition analysis. To examine the effect of subject attrition on the pool of subjects during intervention, attrition analyses on demographic and pretest variables were conducted on the 10 subjects who dropped out during the first year of intervention. Since all attrition occurred in the Classroom + PIE group, the attrition analysis compared these subjects only with those that remained in the Classroom + PIE group. These data are presented in Tables 8.3 and 8.4.

Of the 29 variables examined for differences between those subjects who remained in the study and those who dropped out, there was a statistically significant difference on only one pretest score from the Family Support Scale (FSS). Parents who dropped out of the training group reported less support as measured by the FSS. These analyses indicate that attrition was not systematic and did not bias the outcome of the intervention.

Table 8.3

Attrition Analysis on Demographic Characteristics of Subjects Who Remained or Dropped from the Des Moines Parent Involvement Study

	Remained◆			Dropped				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Age of child in months at pretest	52.3	(11.9)	34	48.4	(12.5)	10	.37	.32
• Age of mother in years at pretest	30.8	(4.8)	33	28.7	(5.0)	9	.24	.43
• Age of father in years at pretest	33.1	(6.1)	27	35.0	(5.9)	7	.46	-.32
• Percent Male'	73.5		34	80.0		10	.69	-.09
• Years Education for Mother	12.6	(1.9)	34	12.0	(1.8)	10	.35	.32
• Years Education for Father	12.8	(2.6)	31	12.4	(3.5)	8	.72	.14
• Percent with both parents' living at home	70.6		34	60.0		10	.54	.30
• Percent of children who are' Caucasian	91.3		34	70.0		10	.21	.79
• Hours per week mother employed	5.1	(11.0)	34	6.4	(13.6)	9	.76	-.11
• Hours per week father employed	33.3	(22.3)	29	28.0	(26.8)	5	.64	.23
• Percent of mothers' employed as technical managerial or above	2.9		34	0.0		10	.54	.21
• Percent of fathers' employed as technical/ managerial or above	37.9		29	33.3		6	.84	.03
• Total household income	$21,632	($18,323)	34	$27,400	($28,417)	5	.54	-.30
• Percent with mother as' primary caregiver	97.1		34	100.0		9	.46	-.26
• Percent of children in' daycare	3.5		34	4.4		9	.62	-.46
• Number of siblings	1.5	(0.8)	34	1.4	(1.4)	10	.88	.10
• Percent with English as' as primary language	100.0		34	100.0		10	.99	.00

' Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "0."

$$ES = \frac{\bar{x}\text{ (Remained)} - \bar{x}\text{ (Dropped)}}{\text{SD (Pooled)}}$$

ESs for percentage values are based on a probit transformation. The sign of the effect size only indicates direction of result, no value judgments are intended.

◆ All subjects who dropped were in the Classroom + PIE group. Therefore, only subjects who remained in the Classroom + PIE groups are used in these comparisons.

Table 8.4

Attrition Analysis on Pretest Measures of Subjects Who Remained or Dropped from the Des Moines Parent Involvement Study

	Remained[*]			Dropped				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Battelle Developmental['] Inventory (BDI)								
DQs for:								
Personal/Social	67.5	(18.5)	34	61.4	(11.4)	10	.22	.45
Adaptive Behavior	63.1	(22.1)	34	66.9	(10.8)	10	.88	-.06
Motor	62.6	(22.0)	34	68.9	(16.3)	10	.89	-.05
Communication	57.5	(20.6)	34	58.0	(20.2)	10	.69	.14
Cognitive	64.0	(19.6)	34	66.0	(20.0)	10	.62	.18
TOTAL	62.6	(16.7)	34	62.9	(11.7)	10	.66	.16
• Parenting Stress Index (PSI)[♦]								
Child Related (range 30 to 250)	117.4	(18.4)	34	119.0	(15.0)	10	.80	.09
Other Related (range 54 to 270)	131.6	(28.8)	34	122.1	(19.2)	10	.34	-.35
TOTAL (range 101 to 505)	248.9	(43.3)	34	241.1	(29.5)	10	.60	-.19
• Family Resource Scale[♠] (FRS) (range 30 to 150)	116.3	(19.5)	34	117.2	(19.0)	10	.89	-.05
• Family Inventory of Life[♦] Events (FILE) (range 0 to 71)	12.0	(8.0)	34	9.1	(7.4)	10	.32	-.37
• Family Support Scale[δ] (FSS) Total Score (range 0 to 4)	2.2	(0.8)	33	1.7	(0.4)	10	.02	.68

['] Statistical analyses for BDI scores were conducted using raw scores for each of the scales. For ease in interpretation, the information in this table has been converted from the raw scores to a ratio Development Quotient (DQ) by dividing the "age equivalent" (AE) score reported in the technical manual for each child's raw score by the child's chronological age at time of testing. ES and p value are based on raw scores.

[♠] Analysis of the FRS is based on raw scores indicating the number of resources reported by the family as being available. Higher scores are considered better.

[♦] Analysis for the PSI and FILE are based on raw scores. Lower scores are considered better.

[δ] Analysis for the FSS is based on the sum of the perceived support score divided by the number of sources of support available. Higher scores are considered better.

$$ES = \frac{\bar{x}\ (\text{Remained}) - \bar{x}\ (\text{Dropped})}{\text{SD (Pooled)}}$$

The sign of the ES is reversed for the PSI, FILE, and FACES, as lower scores are preferred.

[*] All subjects who dropped were in the Classroom + PIE group. Therefore, only subjects who were in the Classroom + PIE group are used in these comparisons.

Intervention Programs

The Des Moines Public School System provided educational services to preschool-aged children, ages 3 through 6, who exhibited developmental delays or who had disabilities. These children received classroom-based, half-day, 5-day-per-week intervention services. Children received services in educational formats (i.e., large group, small group, one-to-one) according to individual needs from special education teachers and teacher associates (paraprofessionals). Language and motor therapists assessed children, provided teachers with objectives, helped teachers integrate instructional therapeutic activities into on-going routines, and provided individualized services as needed. Teachers were free to use various curricula or to develop their own objectives when developing intervention goals and strategies.

The Des Moines Public School Early Intervention Program provided services to a wide variety of children with disabilities, from those exhibiting mild delays to those exhibiting more severe disabilities. The majority of children served were Caucasian, and a wide variety of SES levels were represented. As part of these services to children, parents were regularly involved in IEP meetings; teachers attempted to include and keep parents informed of classroom activities as child and parent needs dictated. In practice, this resulted in regular contacts with parents regarding child progress and participation at IEP meetings, but little else.

The purpose of the research study was to compare the effects of their current service delivery system with the same system enhanced by the inclusion of one type of systematic parent involvement. In both the control and experimental conditions, children received services in the classroom-based Des Moines Public School Early Intervention Preschool Program. No changes were made to this system for the purposes of the study. Children in the classroom and parent involvement (classroom + PIE) intervention were not segregated by classroom or teacher in the classroom-based service (i.e., all classrooms contained children in both groups). In the experimental group, parents of children enrolled in the early intervention program were exposed to a systematic parent curriculum. In their first year of involvement, parents were involved in the Parents Involved in Education (PIE I) package (Pezzino & Lauritzen, 1986). Parents whose children remained in the program for a second year and were in the experimental group were involved in the Parents Involved in Education II (PIE II) package (Durbala & Hollinger, 1988). A schematic detailing group assignment was presented earlier in Figure 8.1.

Classroom-Only intervention. Children assigned to this group attended an existing classroom-based, half-day, 5-day-per-week intervention program in which they received small group and individualized teaching sessions from special education teachers and paraprofessional aides. All teachers were certified and were responsible for supervision of their respective aides. None of the aides were certified as teachers. The training for aides consisted mostly of periodic inservices provided by the school district that teachers, aides, and support staff attended, as well as on-the-job training provided by their respective teachers and the collaborating speech and motor therapists. Each class of approximately 10 children had one special education teacher and one aide. Because each child's program was "IEP driven," motor and speech therapists' contact with children varied widely. In general, a motor and speech therapist was present in each class for the equivalent of 1-day-per-week. During a typical day, children were instructed in the motor, speech and language, self-help, cognitive, and social skills areas. As part of the regular services to children, parents were involved in IEP meetings, and teachers provided parents with IEP updates.

The CAPER, along with other curriculum-linked assessment tools, were used in determining intervention goals and strategies. Intervention activities were developed from comprehensive assessments and items drawn from a number of curricula. Teachers were free to select curriculum based on child need. The skill sequences in the curricula used extended beyond the child's current level of functioning, and functional skill training routines were included in the curricula to the degree appropriate.

__Classroom + PIE intervention__. In addition to the classroom-based service described above, parents of children in this group were offered parent meetings organized around the PIE curricula. PIE I training modules were taught by the preschool program support staff and were designed to provide parents with a systematic, conceptual, and hands-on experience in areas such as child development, observation and recording, targeting intervention behaviors, teaching processes, decision making, and communicating with professionals. The training format consisted of small-group lecture, discussion, and demonstrations. The average small group size was between 8 and 12 parents. PIE sessions consisted of 16, 2-hour meetings presented roughly once per week. PIE sessions also included a social support component in which parents had the opportunity to share feelings and express problems, challenges, and other issues associated with their lives. Parents were primarily responsible for determining the agenda for the social support component of the session. This occupied the first part of the session and focused on issues such as problems with relatives, finding day care, etc. In addition to these sessions, parents were asked to practice the training activities at home with their children. They were asked to choose a target behavior for the child (such as a self-help or behavioral skill; e.g., compliance, dressing, etc.), implement an intervention program, and measure progress by comparing successful completion of tasks before and after intervention.

Parents whose children remained in the preschool program for a second year continued in a systematic parent intervention, but through a different intervention package. The children continued in appropriate classroom-based services. Parents attended meetings structured by the __Parents Involved in Education II__ (PIE II) curriculum (Durbala & Hollinger, 1988). The PIE II was developed based on a parent needs assessment and focused on parent support issues. Issues addressed included:

dealing with parent stress, developing parent communication skills, teaching problem-solving skills, and providing information on areas of interest. The training format for PIE II was the same as PIE I, except 12 sessions were held. Parent home activities that were presented focused on support (e.g., practice parent-focused stress reduction technique, dealing with emotional issues of siblings) rather than child training issues. As in PIE I, a social support component was available at the end of each session.

PIE I and PIE II were conducted by preschool program support staff (e.g., school psychologist, speech and language therapists, consultant, nurse). Each PIE group was facilitated by a team of two staff members. All parent facilitators received instruction in PIE I and PIE II by their respective developers prior to its initial implementation. Meetings were primarily attended by the children's mothers. To prevent contamination of those parents in the Classroom-Only group from being affected by the PIE program, classroom teachers and aides were not involved in the PIE meetings and were only indirectly aware of the goals of PIE. Table 8.5 lists session topics for PIE I and PIE II.

The intent of the PIE I sessions was primarily to give parents the knowledge and abilities that would enable them to serve as interventionists in the home setting. PIE I was based on the philosophy that child progress can be maximized by training parents as interventionists and that the skills parents learn (i.e., their success as an interventionist) will allow the family to more competently function (i.e., by reducing parent stress and uncertainty). In contrast, although the primary intent was also to provide knowledge, the knowledge gained in PIE II dealt more with information on the effect of a child with a disability on the family, and strategies to normalize the functioning of the family. The philosophy behind this approach ties into the ecological or systems model of development (Bronfenbrenner, 1979; Krauss & Jacobs, 1990), in that positive changes in the family are expected to have positive effects on each individual family member.

Table 8.5

Content of PIE I and PIE II

Session	Topic
PIE I	
1.	Introduction and overview
2.	Objective observation of child behavior
3.	Defining and measuring behavior
4.	Principles of behavior management
5.	Analyzing behavior chains
6.	Theories of child development
7.	Testing and assessment
8.	Criterion-referenced assessment
9.	Developing learning objectives
10.	P.L. 99-457 and IEPs
11.	Intervention strategies
12.	Factors related to teaching success
13.	Practice teaching session
14.	Determining appropriate interventions
15.	Communicating with professionals
16.	Review, comments, concerns, questions
PIE II	
1.	Parent needs assessment and introduction
2.	Child development and behavior management
3.	Stress reduction
4.	Strategies for improving social and language skills
5.	Strategies for improving self-help and cognitive skills
6.	Communication
7.	The grief process
8.	Community services
9.	Feelings of siblings and extended family members
10.	Understanding my child's rights: Dialogues with professionals
11.	Promoting family fun
12.	Review, questions, and evaluation

In addition to the PIE, parents in the Classroom + PIE group were provided the opportunity to attend four sessions conducted by the school nurse. These sessions focused on involvement of both spouses, where possible, and on facilitating communication between families. These sessions were informal in nature and focused on information provision, such as a discussion on child nutrition, or on activities (e.g., a family swim night, making gifts at Christmas time).

Impacts on Treatment

During and after intervention, the possibility of uncontrolled events occurring either within or external to the intervention exists. These uncontrolled events can potentially impact on outcome variables. The failure to obtain these types of data can potentially result in an erroneous conclusion (Barnett et al., 1987; Cooke & Poole, 1980). Data that may potentially impact treatment are frequently included under the rubric of treatment verification (Cooke & Poole 1980). Examples of treatment verification variables include child attendance at the intervention program and parent attendance at the PIE sessions. Data collected in this study encompasses aspects of treatment verification as well as other potential impacts on treatment. These other potential impacts on treatment are referred to as contextual variables. Examples of contextual variables include outside events which may impact on families and intervention services obtained outside of the program under investigation. The critical need for these types of data has been discussed in the early intervention literature (LeLavrin & Wollery, 1992).

This section will examine data obtained on treatment verification and contextual factor variables. For ease of presentation, these treatment verification and contextual factor variables will be referred to as potential impacts on treatment, except in subanalyses that examine a single measure or area.

One year of intervention. Treatment verification/contextual data are presented in Table 8.6 for subjects receiving one year of intervention. Child attendance data for basic services and parent attendance data for parents' training sessions were recorded throughout the year. Child attendance was recorded daily, and parent attendance data (for the Classroom + PIE group) was recorded weekly; these data were sent to EIRI on a monthly basis. An initial analysis of attendance data indicates no difference in child attendance rates as a function of group placement (Table 8.6). Average attendance for all subjects was 88.2% of possible school days. Average PIE

Table 8.6

Treatment Verification/Contextual Data for Subjects Receiving One Year of Intervention for Des Moines Study

Variable	Classroom-Only $\bar{x}$	Classroom-Only (SD)	Classroom-Only n	Classroom + PIE $\bar{x}$	Classroom + PIE (SD)	Classroom + PIE n	p Value	ES♦
Treatment Verification								
• Average length of intervention in program days	134.7	(29.0)	42	133.1	(31.8)	34	.83	.06
• Percent child attendance	87.3	(7.9)	38	90.0	(6.6)	34	.13	.34
• Parent PIE attendance	---	---	---	47.6	(22.0)	34	---	---
• Additional Services received· outside the intervention program								
Percent receiving outside'' speech therapy	7.3		41	9.1		33	.79	.12
Percent receiving outside'' motor therapy	7.3		41	6.1		33	.83	-.05
Contextual Variables								
• General health of child'	2.0	(0.5)	39	1.9	(0.7)	32	.66	-.20
• Teacher rating of parents•	5.3	(2.0)	40	7.0	(1.9)	34	.00	.85
• Parent satisfaction	24.9	(2.5)	29	25.1	(2.9)	26	.73	.08
• Family Resource Scale	121.5	(17.0)	41	117.7	(18.9)	34	.36	-.22
• Percent with two parents'' living at home	47.6		42	73.5		34	.02	.64
• Family income	14,397	(15,597)	39	22,147	(18,734)	34	.06	.50

' Based on a parent rating of the child's health where 1 = worse than peers, 2 = same as peers, 3 = better than peers.

Satisfaction is based on the sum of seven questions that deal with various aspects of satisfaction with the classroom-based program (range = 7 - 28). Higher scores indicate greater satisfaction.

• Teacher rating is based on the sum of three questions assessing parent support, knowledge, and attendance at school activities (range = 3 - 9). Higher scores indicate a better rating.

· Data are based on parent report, obtained at posttest, of time child received the service outside of school during the past year.

♦ $$ES = \frac{\bar{x}\ (\text{Classroom + PIE}) - x\ (\text{Classroom Only})}{SD\ (\text{Classroom Only})}$$

'' Statistical analyses for these variables were based on a t-test where those receiving services were scored "1" and those not receiving services "0." Effect sizes are based on a probit transformation of percentage data.

class attendance by parents at the training sessions was 47.6%. Fifty-seven percent of parents attended between 5 and 11 classes; only 13% of parents (5 parents) attended more than 75% of the time. These absences occurred in spite of repeated attempts by program staff to encourage regular attendance. The local site coordinator regularly called absent parents to promote attendance. These data pertain only to PIE I.

A description of quality of parent involvement was also gathered annually from a direct intervenor (teacher) who worked most closely with the respective parent. The data obtained was the intervenor's perception (low, average, high) of how a parent rated on attendance, knowledge, and support. These data are presented in Table 8.6. Teachers rated parents in the Classroom + PIE group as having a higher quality involvement with the school program. This occurred even though teachers were not directly informed of child group placement (although information could have been shared by parent and teacher or indicated through other cues).

In addition to the intervenor's rating of parents, parents were asked to rate their satisfaction with the program (see Table 8.6). Parents rated the intervention program on seven questions that assess satisfaction in a variety of areas (e.g., staff, participation, communication, etc.). Parents in both groups were equally satisfied with the classroom-based program.

Health data on each child were also obtained. Data on hospitalizations (and length), days with fever, a general health rating of the child, and other factors were collected. Data on child general health are presented in Table 8.6. No differences between the study groups were found on any of the health measures.

Teachers in Des Moines were also evaluated annually by their immediate supervisor. These data are relevant to treatment verification. Teachers were rated by their supervisor either as being satisfactory or as needing training. The Des Moines School District uses only two rating levels as per an agreement with the local teachers' union, and no other evaluations can be conducted as per the contract. All teachers of subjects involved in this study received a satisfactory rating.

Additionally, information was obtained at reassessment on the amount of time each child spent in various activities/therapies such as daycare, speech therapy, etc. outside of the intervention program. The data for the two most frequently occurring additional services are presented in Table 8.6. No group differences were found.

Contextual data on parents' perception of family resources (based on the Family Resource Scale), and information on family income and if two parents were living in the home at Reassessment #1, are presented in Table 8.6. A statistically significant difference was found on two parents in the home and family income. These variables were considered as covariates in later analyses but did not correlate with outcome variables. No differences were found on the other measures.

Two years of intervention. Treatment verification/contextual data for subjects receiving two years of intervention (see Figure 8.1) are presented in Table 8.7. These data are presented by first and second year of intervention. Variables on which these data were obtained were discussed previously and will not be repeated. The groups were not significantly different on any of these variables in either year.

Table 8.7

Treatment Verification/Contextual Data for Subjects Receiving Two Years of Intervention Presented by First and Second Year of Intervention for the Des Moines Parent Involvement Study

	First Year								***Second Year***							
	Classroom-Only			Classroom + PIE					Classroom-Only			Classroom + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	P Value	ES◆
Treatment Verification																
• Percent child attendance	88.3	(7.3)	12	89.0	(6.1)	19	.77	.10	88.4	(5.6)	14	88.9	(11.3)	18	.89	.09
• Additional Services' received outside the intervention program																
Percent receiving'' outside speech therapy	0.0		15	5.2		19	.71	.13	0.0		12	17.8		17	.28	.38
Percent receiving'' outside PT/OT therapy	6.7		15	0.0		19	.72	-.25	0.0		12	0.0		17	---	.00
Contextual Variables																
• General health of child	1.9	(0.5)	15	1.8	(0.8)	18	.89	-.20	1.9	(0.7)	14	1.8	(0.6)	18	.69	-.14
• Teacher rating of parents•	6.4	(1.9)	14	7.2	(1.9)	19	.25	.42	7.1	(1.7)	14	8.0	(1.4)	16	.11	.53
• Parent satisfaction'	25.0	(2.2)	14	24.9	(3.1)	19	.91	-.05	26.7	(3.0)	7	26.3	(5.5)	15	.84	-.13
• Family Resource Scale	121.1	(18.0)	15	117.3	(22.2)	19	.59	-.21	124.1	(17.0)	14	118.3	(27.6)	19	.50	-.34
• Percent with two** parents living at home	53.3		15	79.0		19	.12	.64	60.0		15	68.4		19	.62	.21
• Family income	20,346	(21,665)	13	25,868	(20,509)	19	.47	.25	23,167	(26,843)	12	27,656	(21,894)	16	.63	.17

Based on a parent rating of the child's health where 1 = worse than peers, 2 = same as peers, 3 = better than peers.

' Satisfaction is based on the sum of seven questions that deal with various aspects of satisfaction with the classroom-based program (range = 7 - 28) in the first year. In the second year, satisfaction is based on the sum of eight questions that deal with aspects of satisfaction related to the parents participation in the child's educational program (range = 8 to 32). Higher scores indicate greater satisfaction.

• Teacher rating is based on the sum of three questions assessing parent support, knowledge, and attendance at school activities (range = 3 - 9). Higher scores indicate a better rating.

"---" = t-test not conducted because of no variance.

◆ $$ES = \frac{\bar{x}\text{ (Classroom + PIE)} - \bar{x}\text{ (Classroom Only)}}{\text{SD (Classroom Only)}}$$

'' Statistical analyses for these variables were based on a t-test where those receiving services were scored "1" and those not receiving services "0." Effect sizes are based on a probit transformation of percentage data.

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Parent satisfaction data obtained after the second year of intervention were different from those obtained earlier. Satisfaction questions focused on the parents involvement in, and understanding of, the child's educational program. This was done in an attempt to make the satisfaction questionnaire more sensitive to aspects of parent involvement. The data presented in Table 8.7 indicate no group differences using this new questionnaire.

Average attendance at parent training sessions during the first year of intervention ranged from 2 to 13 of 16 possible PIE I sessions, with a mean of 7.8 sessions (SD = 3.0). During the second year, of 12 PIE II sessions, parents attended from 0 to 12 sessions with a mean of 4.6 sessions (SD = 4.4). Regular parent contacts were made to nonattending parents in an attempt to increase attendance.

The concern that the Classroom + PIE I + PIE II subgroup of the Classroom + PIE group might have been different from the other parents in the Classroom + PIE group that received only PIE I was a concern that arose in relation to attendance at parent meetings during the first year. A t-test between these two subgroups was completed on attendance at PIE I meetings, and no difference in attendance was found ($\underline{t}$ = 1.08, $\underline{p}$ = .29).

Site review. One source of treatment verification data is information from a site review conducted annually by the site coordinator. The first site review was conducted on April 10, 1987, and a second site review was conducted on May 10 and 11, 1988. The purposes of these reviews were to: (a) collect information about the nature and quality of early intervention services that were being delivered, (b) verify that the research being conducted by EIRI was being implemented as intended, and (c) collect assessment data that may have been useful to site administrators to guide internal changes and for use when seeking technical assistance.

Purposes (a) and (b) are of primary interest in this report. The Des Moines School District was conducting the research as intended by EIRI. Overall findings indicated that: the preschool program was of high quality; it was staffed by enthusiastic and qualified professionals; classroom environments were safe and appropriate; teachers emphasized functional skills in naturally occurring environments; the program was competently administered, used up-to-date curricula, and had proper evaluation, assessment, and progress procedures; parent training sessions were well organized and well facilitated; and parent participation was good. (For more information, a copy of the site reviews can be obtained.)

Family life events. Life events that occur to a family prior to, during, and after intervention are contextual factors that may also potentially impact on outcome data. To examine this possibility, the Family Inventory of Life Events and Changes (FILE) (McCubbin et al., 1983) was administered at Pretest and Reassessment #1 and #2 (see Tables 8.12 and 8.14 for a description of this measure). This measure was discontinued after Reassessment #2 based on parent request.

The data obtained from the FILE are presented in Table 8.8. These data indicate that the families in the Classroom + PIE group experienced significantly more life events; a factor which may impact on treatment.

Table 8.8

Family Life Events Scores for Des Moines Parent Involvement Study

	Classroom-Only			Classroom + PIE			p Value
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	
Pretest*	8.1	(4.8)	41	12.0	(8.0)	34	.02
Reassessment #1*	7.4	(5.3)	41	10.8	(6.9)	34	.02
Reassessment #2*	6.1	(5.0)	24	9.7	(7.4)	25	.05
Reassessment #5**	24.6	(55.8)	36	41.5	(56.2)	31	.22
Reassessment #6**	44.7	(48.8)	36	39.1	(58.5)	30	.68
Reassessment #7**	42.8	(44.6)	34	39.0	(57.7)	30	.77

* FILE, range = 0 to 71 ** Major Life Events Scale, range = 0 to 457

These results clearly indicate the differential occurrence of family life events. This finding was considered when conducting outcome analyses and the use of the FILE as a covariate was examined. The FILE did not correlate significantly with child outcome variables, nor with the majority of family functioning variables (see Results and Discussion section for more information).

Although the FILE was not administered at Reassessment #3 or #4, the Holmes and Rahe Major Life Events Scale (Holmes & Rahe, 1967) (see Table 8.14 for a description of this measure) was administered at Reassessments #5-#7 to gather additional information on longitudinal aspects of life events, and the results of analysis on this measure are presented in Table 8.8. No statistically significant differences were found at Reassessment #5, #6, or #7 on the Main Life Events Scale for negative life events (the data are presented in Table 8.7) or on stress related to these life events ($p = .50$, $p = .74$, and $p = .87$, respectively).

Post intervention data. It is important to assess events, which happen to children and families following intervention, that may impact on outcome measures being used. The data collected on these events, although no longer measures of treatment verification, may be important to the appropriate interpretation of longitudinal data. All data collected post-intervention will be referred to as contextual factors.

Data collected post intervention consisted of information regarding the child's health and information regarding services the child received outside of those provided by school placement. (Hours of outside services data were not available for Reassessment #4.) These data are presented in Table 8.9. Some demographic variables and perceptions of family resources may potentially impact on outcome measures; these are also presented in Table 8.9. All post-intervention data were obtained from parent report at each reassessment.

No differences were found between groups in the health of the subjects for any of the reassessments on any of the health variables examined. In terms of extra therapies received by subjects, a difference occurs in the amount of speech therapy subjects received outside of school. Subjects in the Classroom + PIE group received more speech therapy as reported at Reassessment #3, but not at Reassessment #2, #5,

Table 8.9

Contextual Data for Reassessment #2 - #7 for Des Moines Parent Involvement Study

	Classroom-Only			Classroom + PIE				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES[^]
REASSESSMENT #2								
• Average number of[♦] Intervention Days	197.2	(82.1)	87	220.8	(77.4)	33	.22	.29
• General health of child[&]	1.9	(0.6)	26	1.9	(0.5)	26	.66	.00
• Therapies received outside[*] school program								
Percent receiving outside[**] speech therapy	8.8		34	22.6		31	.13	.52
Percent receiving outside[**] PT/OT therapy	2.9		34	3.2		31	.95	.04
• Family Resource Scale	124.8	(14.6)	35	114.4	(24.8)	33	.02	-.71
• Percent with two parents[**] living at home	51.4		37	66.7		33	.20	.37
• Family Income	16,800	(19,316)	30	23,690	(19,366)	29	.18	.36
REASSESSMENT #3								
• General health of child[&]	2.1	(0.5)	36	2.0	(0.7)	31	.45	-.20
• Therapies received outside[*] school program								
Percent receiving outside[**] speech therapy	0		25	17.0		23	.00	.95
Percent receiving outside[**] PT/OT therapy	0		25	8.7		23	.04	.61
• Family Resource Scale	122.7	(12.8)	37	120.3	(23.9)	31	.60	-.19
• Percent with two parents[**] living at home	50.0		36	61		31	.36	.27
• Family Income	15,757	(18,029)	35	22,000	(18,278)	30	.17	.35

(continued)

[&] Based on a parent rating of the child's health where 1 = worse than peers, 2 = same as peers, 3 = better than peers.

[*] Data are based on parent report, obtained at posttest, of time child received the service outside of school during the past year.

"__________" = no data available

[^] $$ES = \frac{\bar{x}\ (\text{Classroom + PIE}) - \bar{x}\ (\text{Classroom Only})}{\text{SD (Classroom Only)}}$$

[**] Statistical analyses for these variables were based on a t-test where those receiving services were scored "1" and those not receiving services "0."

[♦] Data represent days in classroom-based preschool program combined across Reassessment #1 and #2.

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Table 8.9 (continued)

Contextual Data for Reassessment #2-#7 for Des Moines Parent Involvement Study

	Classroom-Only			Classroom + PIE				
Variable	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	$\hat{ES}$
REASSESSMENT #4								
• General health of child*	2.1	(0.6)	34	2.1	(0.5)	32	.97	.00
• Therapies received outside* school program								
Percent receiving outside** speech therapy	—	—	—	—	—	—	—	
Percent receiving outside** PT/OT therapy	—	—	—	—	—	—	—	
• Family Resource Scale*	124.4	(14.8)	35	119.0	(22.8)	32	.25	-.36
• Percent with two parents** living at home	55.6		36	61.8		34	.60	.15
• Family Income*	18,186	(19,537)	35	22,081	(19,175)	31	.42	.20
REASSESSMENT #5								
• General health of child*	2.1	(0.5)	25	2.2	(0.7)	25	.42	.20
• Therapies received outside* school program								
% receiving speech therapy**	5.4		37	6.1		33	.91	.06
% receiving PT/OT**	5.4		37	3.0		33	.63	-.15
• Family Resource Scale*	124.9	(16.2)	35	121.0	(20.0)	31	.39	-.24
• Percent with two parents** living at home	55.3		38	72.7		33	.13	.44
• Family Income*	16,066	(17,418)	38	24,895	(25,170)	33	.09	.51
REASSESSMENT #6								
• General health of child*	2.3	(0.56)	37	2.3	(0.65)	29	.97	.00
• Therapies received outside* school program								
% receiving speech therapy**	6		36	3		29	.69	-.11
% receiving PT/OT**	6		36	3		29	.69	-.11
• Family Resource Scale*	120.0	(16.9)	36	120.9	(20.8)	30	.85	.05
• Percent with two parents** living at home	54.1		37	65.6		32	.36	.22
• Family Income*	$21,342	(23,228)	35	$30,879	(26,492)	29	.14	.38
REASSESSMENT #7								
• General health of child	2.2	(.58)	37	2.3	(.63)	33	.70	.17
• Therapies received outside school program								
% receiving speech therapy**	5		37	6		33	.89	.03
% receiving PT/OT**	0		37	3		33	.51	.16
• Family Resource Scale	120.9	(18.9)	34	121.4	(21.5)	29	.92	.02
• Total household income	$21,000.	(21,333)	34	33,776	(28,455)	29	.05	.51
• Percent with both parents living at home	54.1		37	60.6		33	.35	.22

(See notes on previous page)

or #6. No differences between groups were found in motor therapies received at any posttest, except at Reassessment #3. However, the overall number of children receiving therapies outside of school is very small at all reassessments. These data suggest that Classroom + PIE subjects may have had a slight advantage over the

Classroom-Only subjects at Reassessment #3 in communication and motor skills because of extra therapy received.

Statistically significant differences were found at different times on the perceptions of family resources and on the contextual demographic variables. Their fluctuation suggest that impacts were not consistent across reassessments. The impact of these contextual differences has been examined at each reassessment, and correlations of these with outcome variables has not been statistically significant.

Test of parent knowledge. A treatment verification variable was a test of parent knowledge administered to parents at most reassessments. The test of parent knowledge was designed as part of PIE I and assessed the degree to which parents learned the concepts taught in PIE I. The test consisted of 30 multiple choice questions and higher scores indicated greater retention of concepts.

Initial analyses (t-tests) of data from the test of parent knowledge indicated that parents in the Classroom + PIE group obtained statistically significantly higher scores than the Classroom-Only group at all reassessments. The results from the test of parent knowledge were reanalyzed to examine differences between parents who received intervention for one year (Classroom + PIE I) vs. two years (Classroom + PIE I + PIE II). Oneway analyses of variance were conducted between these two experimental subgroups and the Classroom-Only group. These data are presented in Table 8.10. Statistically significant differences were found at all reassessments. A Student-Newman-Keuls procedure was conducted to determine specific group difference. The Classroom + PIE I + PIE II cohort performed better than the control group at all reassessments. The Classroom + PIE I cohort performed better than the control group at Reassessments #1 and #3. The classroom + PIE I + PIE II group performed better than the Classroom + PIE group at Reassessments #2 and #4.

These results suggest that those who received PIE intervention had more knowledge of the intervention subject matter than those who had not received the PIE intervention. This finding is consistent with the goals of the PIE intervention and suggests that the PIE intervention was effective in this aspect of knowledge provision. The fact that parents who received two years of PIE intervention recall more information than those only receiving one year of intervention is also consistent with expected intervention outcomes. Although PIE II was different in overall intent, it did provide parents with a forum to use information learned in PIE I. However, this result is partly confounded by the fact that the Classroom + PIE I + PIE II cohort had higher scores prior to receiving the PIE II intervention.

Table 8.10

Test of Parent Knowledge* Scores for Des Moines Parent Involvement Study

	Classroom Only			Classroom + PIE I			Classroom + PIE I + PIE II				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	Direction*	P Value
Reassessment #1	8.6	(4.2)	41	13.9	(5.9)	15	17.2	(5.4)	19	0 < 1 0 < 2	.000
Reassessment #2	10.1	(6.0)	35	12.7	(5.6)	14	17.3	(7.1)	18	0 < 2 1 < 2	.001
Reassessment #3	9.1	(5.3)	37	14.2	(5.8)	13	17.9	(7.2)	18	0 < 1 0 < 2	.000
Reassessment #4	10.0	(5.4)	36	12.7	(5.7)	14	17.3	(7.7)	18	0 < 2 1 < 2	.001
Reassessment #5	9.6	(6.2)	34	12.0	(5.0)	12	18.5	(7.3)	17	0 < 2 1 < 2	.001

* Range = 0 to 30

* Indicates direction of significance based on SNK procedure; 0 = Classroom-Only, 1 = Classroom + PIE, 2 = Classroom + PIE I + PIE II.

Treatment verification analyses. An analysis of the treatment verification data was conducted. The finding of group differences on the intervenor rating of parents (Table 8.6) raised questions regarding the reason for this difference. That is, did the PIE intervention provide parents with skills that enabled them to interact more effectively with teachers, or were the ratings the result of other factors (as pretest differences did exist between groups)? The relation of parent attendance at group meetings (by Classroom + PIE group parents) and parent satisfaction with intervenor ratings were other issues that were of interest.

Correlational analyses were conducted to begin the examination of these issues. Correlations of parent attendance (by Classroom + PIE group parents), intervenor ratings of parents (for all parents), and parent satisfaction (for all parents) with treatment verification measures, family demographic characteristics, and information from posttest family measures were conducted. Data presented in Table 8.11 represent correlations that provide some interesting findings regarding the current data and raise suggestions for further analyses. Intervenor ratings of parents appear related to a number of factors, primarily parent education and income; although child attendance at school and lack of child progress in school also was related to intervenor ratings. When these demographic factors were included in an Analysis of Covariance with intervenor rating (sum of the three areas) as dependent variable and treatment group as independent variable, no differences between groups were found ($F = 2.46$, ES = 0.38, $p = .13$).

Table 8.11

Correlational Analyses of Treatment Verification Data For Des Moines Parent Training Study

Variable	Parent Attendance[a]		Intervenor Rating[b]		Parent Satisfaction[c]	
	r	p	r	p	r	p
• Mother's education	.32	.07	.56	<.000	.11	.25
• Father's education	.37	.05	.51	<.000	-.03	.41
• Family income	.42	.03	.61	<.000	.15	.17
• Child school attendance	.22	.10	.23	.06	.04	.40
• Parent attendance[a]	---	---	.55	.002	.00	.50
• Intervenor rating	.55	.002	---	---	.06	.33
• Parent satisfaction[c]	.00	.50	.06	.33	---	---
• Child progress[d]	-.12	.26	-.20	.06	.04	.38

[a] Based on actual parent attendance at PIE I meetings.

[b] Based on the sum of three questions assessing parent support, knowledge, and attendance as perceived by the teacher at Reassessment #1.

[c] Based on seven questions assessing parent satisfaction obtained at Reassessment #1.

[d] Child progress is based on difference in BDI total raw score from Pretest to Reassessment #1.

Parent education and income was also associated with parent attendance at PIE meetings. Perhaps parents with higher levels of education are more comfortable in a class-like setting and are more willing to attend regularly. Unlike parent attendance at meetings and intervenor ratings, parent satisfaction with the Classroom-Based intervention program is unrelated to parent education, child progress, or intervenor perception. A number of possibilities arise: (a) more sensitive measures of satisfaction may be needed; (b) parents may not have a clear idea of what represents a good versus poor program; or (c) all parents may be truly satisfied.

These treatment verification analyses raise interesting questions for the field of early intervention. Evaluations in the past have overlooked these variables and as a result may have obtained biased data (Casto & Mastropieri, 1986; Cooke & Poole, 1982). These initial analyses make clear the importance of treatment verification data. Treatment verification data not only helps clarify results obtained, but can also raise new areas for investigation.

Cost of Alternative Interventions

The primary purpose of the cost analysis was to provide information for a cost-effectiveness analysis (CA). Briefly, CA is used when evaluating the costs and effects of alternative programs which are attempting to achieve the same outcome or outcomes. Cost-effectiveness results indicate either which program was the most effective for a given cost, or what level of service was available for the least cost (Levin, 1983).

The standard economic approach used to collect the cost data for this study was the "ingredients" approach (Chambers & Parrish, 1983; Hartman, 1979; Levin, 1983). Using this approach, all of the resources or ingredients that were required to make the program operational were identified and assigned a market value or price. This differs from an analysis of the budgeted costs of a program in several ways. Budgeted costs do not always account for all the resources of a given program. For example, programs may borrow resources, either personnel or capital resources, from another program that do not appear on the program's operating budget. In addition, budgets do not account for the social costs of resources. For example, if a program is housed in a building at no cost to the program, there is still a cost associated with that space from the societal perspective. If a program uses volunteers who are "free" to the program, there is also a corresponding cost to their time and labor from the social perspective. These costs are referred to as opportunity costs. This simply means that the true value of a resource is its value in its most productive alternative use. For many of the program ingredients, budgeted costs and social costs were the same. However, wherever they differ, social costs were calculated.

Costs are based on actual expenditures for direct service and administrative personnel, occupancy, equipment, transportation, materials and supplies, and contributed resources. The cost of the classroom-based plus PIE I and classroom-based plus PIE II is simply equal to the cost of the basic classroom-based program available to 210 children (all classroom-based enrolled preschool children) plus the additional cost of PIE I or PIE II for those families who participated in 1987-88. The cost per child was determined by dividing total resource cost in each category by the number of children receiving services in each program. Table 8.12 presents the cost per child in each of these resource categories. All costs are in 1990 dollars. In cases where program costs were compared over several years, costs were adjusted for inflation using the Fixed Weighted Price Index for state and local government purchases (Bureau of Economic Analysis, 1991).

Direct service and administrative costs included salaries plus benefits for each staff member according to the percentage of FTE allocated to each program. Because the program is operated within a public school system, school and general direct administration were included. Occupancy charges included the annual rent for the facility in which the program was housed, all utilities, insurance, and maintenance costs. Equipment costs were based on estimates of the market replacement value of all classroom and office equipment, annualized to account for interest and depreciation. Staff transportation costs for job-related travel were based on actual mileage at $.21 per mile. The average cost per child for children in special education in the school district was used for child transportation costs. The cost for materials and supplies included the annual expense to the program for all consumable items.

Table 8.12

Cost Per Child Per year for Des Moines Study

Resource	Classroom-Based Only	Classroom-Based + P.I.E. PIE I	Classroom-Based + P.I.E. PIE II	Average PIE
Agency Resources				
Direct Service Personnel	$4,214	$5,749	$4,645	$5,197
Administrative Personnel				
Preschool	247	247	247	247
District	1,284	1,284	1,284	1,284
Facilities	224	224	224	224
Equipment	33	33	33	33
Materials/Supplies	40	85	54	70
Transportation				
Child	501	501	501	501
Staff	36	36	36	36
Subtotal	$6,579	$8,160	$7,024	$7,592
Contributed Resources				
Parent Transportation	0	91	54	72
Parent Time	0	772	698	734
Total	**$6,579**	**$9,023**	**$7,776**	**$8,398**

Contributed resources included the value of parent time working at home with their children, attending training sessions, and the time and expense of driving to the sessions. Parents in the PIE I group spent an average of 16.5 hours and PIE II parents spent an average of 9.32 hours in training sessions, and, assuming that parents followed PIE curriculum requirements, 60 hours working at home with their child. In addition, parents in both groups were interviewed via telephone to determine their transportation expenses to attend sessions. These costs were assigned the opportunity cost of $9 per hour; mileage was assessed at $.21 per mile.

Data Collection

It is important to note that the data collected for this study were collected to assess the effects of intervention not only on the children, but also on their families. As noted earlier, pretest data, data from Reassessment #s 1-7, and some data for Reassessment #8 have been collected. The instruments used to obtain data on children and their families, and the administration information on these instruments is presented in Table 8.13. A brief description of each of these instruments is presented in Table 8.14.

Table 8.13

Schedule of Administration and Tests Administered for Des Moines Parent Involvement Study

	Pretest	Reassess. 1	Reassess. 2	Reassess. 3	Reassess. 4	Reassess. 5	Reassess. 6	Reassess. 7	Reassess. 8
CHILD MEASURES									
Battelle Developmental Inventory	X	X	X	X					
Woodcock-Johnson Tests of Achievement					X	X	X	X	X
Scales of Independent Behavior					X	X	X	X	X
Joseph Preschool and Primary[+] Self-Concept Inventory		X	X	X	X				
Stanford-Binet Intelligence[++] Test Form L-M		X							
Developmental SPECS					X				
Pictorial Scale of Perceived Competence & Social Acceptance						X	X	X	
Social Skills Rating System						X	X	X	X
FAMILY MEASURES									
Parenting Stress Index	X	X	X	X	X	X			
Parenting Stress Index (short form)							X	X	X
Family Support Scale[*]	X	X	X		X	X	X	X	X
Family Resource Scale	X	X	X	X	X	X	X	X	X
Family Inventory of Life Events and Changes	X	X	X						
Family Adaptability and Cohesion Evaluation Scales	X	X	X	X	X	X			
CES-D Depression Scale		X	X	X					
Child Improvement Questionnaire		X	X	X	X	X			
Parent as a Teacher Scale			X	X	X				
Comprehensive Evaluation of Family Functioning					X				
Parent Self-Awareness Scale						X			
Holmes and Rahe Major Life Events						X	X	X	X
Family Functioning Style Scale							X		
Dyadic Adjustment Scale[**]							X		

[*] At Reassessment #1, this test was administered to Cohort 2 subjects. This test was not included in the test battery until 1988.

[**] This test was administered at Reassessment #1 to Cohort 1 subjects only. The costs for administering this test were very high and the information being generated did not substantially add to that which was being otherwise collected.

[+] At Reassessment #2, these were completed only for Cohort 1 subjects due to an error caused by the staggered testing of cohorts.

[++] Administered in 1993 to Cohort #1--Reassessment 7, and Cohort #2--Reassessment #6

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Table 8.14

Description of Tests Administered for Des Moines Parent Involvement Study

MEASURES	DESCRIPTION
Battelle Developmental Inventory (BDI) (Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984)	A norm-referenced test of developmental functioning completed through child administration and parent interview. Assesses personal/social, adaptive, motor, communication, and cognitive skills, and provides a total score.
Woodcock-Johnson Tests of Achievement (Woodcock & Johnson, 1989)	A norm-referenced test of achievement. The test consists of nine aspects of scholastic achievement: Letter-word Identification, Passage Comprehension, Calculation, Applied Problems, Dictation, Writing Samples, Science, Social Studies, and Humanities.
Scales of Independent Behavior (SIB) (Bruininks, Woodcock, Weatherman, & Hill, 1984)	The SIB is a norm-referenced test which assesses the functional independence and adaptive behavior of a child. The test is organized into four subdomains: motor skills, social and communication skills, personal living skills, and community living skills.
Joseph Preschool and Primary Self-Concept Screening Test (JSI) (Joseph, 1979)	Assesses the self-concept of children ages 3.6 to 9.11 years via responses to line drawings. It provides a global self-concept score.
Stanford-Binet Intelligence Test Form L-M (Terman & Merrill, 1973)	The Stanford-Binet is a norm-referenced measure of general intellectual ability.
Developmental SPECS (System to Plan Early Childhood Services) (Bagnato & Neisworth, 1990)	Assesses adult perceptions (judgment-based assessment) of child capabilities on 20 developmental dimensions that encompass six domains: communication, sensorimotor, physical, self-regulation, cognition, and self-social.
Social Skills Rating Scale (SSRS) (Gresham & Elliott, 1990)	A norm-referenced measure of child social skills and school success. Ratings are obtained from the child's parent and teacher.
Pictorial Scale of Perceived Competence and Social Acceptance (Harter & Pike, 1984)	A pictorial scale of perceived competence and social acceptance for young children that assesses four domains: cognitive competence, physical competence, peer acceptance, and maternal acceptance.
FAMILY MEASURES	
Parenting Stress Index Short Form (PSI-SF) Abidin, 1990)	This is a short version of the PSI. Three factors are assessed: maternal self-esteem, parent-child interaction, and child self-regulation.
Parent Stress Index (PSI) (Abidin, 1986)	Assesses parent perceptions of stress on the parent-child system. The two main domains are child-related factors and parent factors .
Family Support Scale (FSS) (Dunst, Jenkins, & Trivette, 1984)	Assesses the availability of sources of support as well as the degree to which different sources of support provided are perceived as helpful to families rearing young children.
Family Resource Scale (FRS) (Dunst & Leet, 1985)	Assesses the extent to which different types of resources are perceived as adequate in households with young children. Factors include: General Resources, Time Availability, Physical Resources, and External Support.
Family Inventory of Life Events and Changes (FILE) (McCubbin, Patterson, & Wilson, 1983)	Assesses life events and changes experienced by a family unit during the past 12 months. The specific areas of potential strain covered by the scale include: intra-family, martial, pregnancy and childbearing, finance and business, work-family transitions, illness and family "care," losses, transitions "in and out," and legal.

(continued)

Table 8.14 (continued)

Description of Tests Administered for Des Moines Parent Involvement Study

MEASURES	DESCRIPTION
Family Adaptability and Cohesion Evaluation Scale - III (FACES) (Olson, Portner, & Lavee, 1985)	Provides a general picture of family functioning by assessing the family's level of adaptability and cohesion. Family cohesion assesses degree of separation or connection of family members to the family. Adaptability assesses the extent to which the family system is flexible and able to change in various situations. The scale also has a perceived as well as ideal form that provides an indication of the extent to which current family functioning is consistent with the family's expectations for ideal family functioning.
CES-D Depression Scale (Radloff, 1977)	This scale is a short self-report test designed to measure depression-symptomatology on the general population.
Child Improvement Questionnaire (Devellis et al., 1985)	The questionnaire has been adapted from the Child Improvement Locus of Control (CILC). The CILC assesses parental perceptions of factors that affect the progress of their developmentally impaired child. Factors assessed are: chance, efforts by professionals, the child's efforts, parent efforts, and divine intervention.
Parent as a Teacher Scale (PAAT) (Strom, 1984)	Assesses parent attitudes toward aspects of the parent-child interactive system. The PAAT responses are grouped into five areas: creativity, frustration, control, play, and teaching-learning.
Comprehensive Evaluation of Family Functioning (CEFF) (McLinden, 1989)	Assesses areas in which a family having a child with special needs may be affected. Areas assessed are: time demands, acceptance, coping, social relationships, financial demands, well-being, and sibling relationships.
Parent Self-Awareness Scale (PSAS) (Snyder, Weildreyer, Dunst, & Cooper, 1985)	Assesses parent perceptions of empowerment in the areas of decision making, obtaining information, and in interactions with self and others.
Holmes & Rahe Major Life Events (Holmes & Rahe, 1967)	Assesses parent stress resulting from major life events that occurred within the past year.
Dyadic Adjustment Scale (DAS) (Spanier, 1976)	The DAS contains 32 items that provide information on overall marital adjustment and four subfactors: consensus, cohesion, satisfaction, and affection.
Family Functioning Style Scale (FFSS) (Deal, Trivette, & Dunst, 1988)	The scale is a 26-item scale that assesses the extent to which the person (i.e., mother) believes that their family is characterized by different strengths and capabilities.

Recruitment, training, and monitoring of diagnosticians. Initially, diagnosticians were doctoral candidates in the School Psychology program at Iowa State University and other professionals in the community (i.e., speech/language therapists and teachers). Their training involved approximately 4 hours of independent study and 8 hours of group training. Each examiner, after administering a minimum of three practice BDIs, was required to pass a quality-control test administration before they were permitted to test. Further, approximately 10% of each examiner's test administrations were "shadow scored" during each testing period. Interrater reliability data on the BDI reveal coefficients consistently above .90. All protocols were also rescored by EIRI clerical staff and errors indicated. This rescoring has resulted in only minor errors being discovered, increasing confidence in the examiners. These examiners also administered the Peabody Picture Vocabulary Test (PPVT) to mothers. This was done concurrent with the Reassessment #1 BDI administration. None of the examiners had any involvement with the Des Moines School District program, so the likelihood of their knowing child group assignment was remote.

All Stanford-Binets were administered by three trained doctoral candidates in the Psychology program at Utah State University. All Stanford-Binet examiners were uninformed about the subjects' group assignments. None of the Stanford-Binet examiners had any other involvement with EIRI or the Des Moines Public Schools, so the likelihood of their knowing group assignments was also remote. The Stanford-Binet was administered while the child was in his preschool classroom placement.

During the Spring 1988 reassessment, the Joseph Preschool and Primary Self-Concept Inventory (JSI) was added as a measure. BDI examiners were trained in the administration of the JSI. Two examiners administered all JSIs (in 1988) to children while they were in their classroom placement. In following years, the JSI was administered with the other child measures.

At Reassessment #4, two BDI examiners were trained in the use of the Woodcock-Johnson Tests of Achievement and the Scales of Independent Behavior. Certification requirements for administering these tests was the same as those established for the BDI. The mean interrater reliability on these instruments for Reassessment #4 was 97.9%. These two examiners also completed Reassessment #5 testing. In addition, a third diagnostician was trained. The mean interrater reliability on these instruments at Reassessment #5 was 98.6%. These three examiners have conducted all Reassessment #6, #7, and #8 testing to date. Reliability was 97.8% at Reassessment #6 and 98.2% at Reassessment #7.

Administration of family measures has varied. At pretest, Reassessment #1, and for some subjects at Reassessment #2 (see second reassessment below), the measures were administered to parents while in a group by the site liaison. Parents were not allowed to discuss these measures during the session (except for individual questions to the liaison) and parents were requested not to discuss this information with other parents. This method of administration was selected to help ensure that examiners remained "blind" to subject group placement.

For some subjects in Reassessment #2, and for subsequent reassessments, parents completed family measures during and following the time child measures were being administered. Examiners were familiarized with procedures to be followed for the family measures and with the individual measures.

Pretest. The following procedures were completed at pretest. Parents of each child participating in the study completed an informed consent form and provided demographic information. In the first of two pretesting sessions, parents (usually the mother) completed the family measures. In a second pretesting session, which took place within 2 weeks of the first session, children were administered the Battelle Developmental Inventory (BDI). Parents were paid $20 after both pretesting sessions were completed.

First reassessment. At the first reassessment, a similar course of events occurred. Family measures were administered in one session and child measures during another session (see Table 8.11). At this and all subsequent reassessments, demographic information was updated and parents provided information relevant to treatment verification. At this reassessment only, mothers were administered the Peabody Picture Vocabulary Test--Revised (Dunn & Dunn, 1981). Parents were paid for participating in reassessment activities. Payment was provided at all subsequent reassessments.

Second reassessment. At Reassessment #2, events differed slightly depending on whether children were enrolled in the preschool intervention program or a school-age program. Children in the preschool intervention program were tested in the same manner as Reassessment #1. Parents and children in the school-age program were tested during a single session. This change from a two to one session format for reassessment activities was the only different aspect of the process.

Third reassessment. At Reassessment #3, all measures were administered using the single session format.

Fourth reassessment. The format for Reassessment #4 activities was the same as that described for Reassessment #3. At Reassessment #4, the BDI was no longer used. The mean age for subjects at this posttest was 94 months. The BDI is inappropriate for children at this age level. A number of ceiling problems had been noted on the BDI at Reassessment #3. Child measures were changed at this point for all subjects (see Tables 8.13 and 8.14). In addition, information was obtained from each child's teacher on classroom placement and the teacher's judgment of child skills (SPECS). Parent permission to contact teachers was obtained. Teachers were mailed forms to be completed with appropriate descriptive information. Teachers were remunerated for their participation.

Fifth reassessment. Although the Woodcock-Johnson and SIB continued to be used, the JSI and SPECs were replaced by the Perceived Self-Competence Inventory and SSRS. These changes reflect the increasing ages of the children. The SSRS is completed by both the parent and teacher. Some changes in family measures have also occurred (see Tables 8.13 and 8.14). These changes result in no loss of information, but instead use new instruments to obtain equivalent information. These changes reflect study sensitivity to parental input, results from data obtained on earlier measures, and the increasing age of children. Teacher information was again obtained.

Sixth, seventh, and eighth reassessments. Reassessment activities mirror those of the fifth reassessment. Some changes occurred in family measures (see Tables 8.13 and 8.14). The Pictorial Scale of Perceived Competence and Social Acceptance was dropped as a measure at Reassessment #8. Reassessment #7 data indicated that approximately one-third of the sample could not reliably complete the test and the remainder of the sample were approaching or at the test ceiling. Given these data, and concerns that the Pictorial scale for older children (Self-Perception Profile for Children; Harter, 1985) was not appropriate for this sample, the measure was not administered.

Cross-reassessment issue. An issue that crosses reassessments is data related to parent-child interaction. These data were collected to address concerns regarding qualitative aspects of the parent-child system that may have changed. These data were collected on all children during reassessment in Summer 1990. These data have been analyzed across reassessments. A videotape protocol was developed to record parent-child interactions. Examiners were trained in this protocol and recorded interactions as the final part of the reassessment session.

Results and Discussion

This section will present data from all reassessments.

Comparability of Groups on Pretest Measures

Comparability of groups at pretest for each reassessment will be presented in this section. Analyses are reported separately for each reassessment because of the change in number of subjects at each reassessment.

Based on available demographic data (presented earlier in Table 8.1), there was a slight advantage for those subjects whose parents were involved in the Classroom + PIE group. The Classroom + PIE group families were better educated, held higher SES occupations, and had higher annual incomes.

Additional information on the comparability of groups is presented in Table 8.15. This table presents data from the core measures at pretest for the Classroom-Only and Classroom + PIE groups. On the BDI, there is a slight advantage in favor of the Classroom-Only group subjects in the adaptive and motor domain areas ($p < .10$).

Table 8.15

Comparability of Groups on Pretest Measures for Des Moines Parent Involvement Study

	Reassessment #1								**Reassessment #2**							
	Classroom-Only			Classroom + PIE					Classroom-Only			Classroom + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Battelle Developmental[*] Inventory (BDI)																
Personal/Social	108.4	(27.5)	42	106.3	(23.4)	34	.73	-.08	108.2	(29.0)	37	105.8	(23.5)	33	.70	-.08
Adaptive Behavior	72.0	(15.0)	42	65.1	(16.8)	34	.06	-.46	71.2	(15.7)	37	65.6	(16.9)	33	.15	-.36
Motor	102.4	(22.2)	42	92.5	(27.0)	34	.08	-.45	100.0	(22.3)	37	92.4	(27.4)	33	.20	-.34
Communication	52.9	(15.3)	42	50.3	(19.1)	34	.52	-.18	51.6	(15.2)	37	50.1	(19.3)	33	.72	-.10
Cognitive	43.2	(13.8)	42	43.0	(17.8)	34	.94	-.01	42.6	(14.6)	37	42.8	(18.0)	33	.95	.01
TOTAL	378.9	(82.6)	42	357.2	(93.1)	34	.29	-.26	373.7	(86.5)	37	356.7	(94.5)	33	.43	-.20
• Parenting Stress Index (PSI)[♦]																
Child Related (range 0 to 30)	118.9	(20.4)	41	117.4	(18.4)	34	.73	.07	118.8	(20.0)	36	117.9	(18.4)	33	.85	.05
Other Related (range 54 to 270)	131.3	(23.7)	41	131.6	(28.8)	34	.97	-.01	130.2	(22.1)	36	132.8	(28.3)	33	.68	-.12
• Family Adaptability and[◆] Cohesion Evaluation Scales (FACES)																
Adaptation (range 10 to 50)	21.7	(6.7)	41	21.9	(3.7)	34	.89	.03	22.0	(7.0)	36	22.0	(3.7)	33	.97	.00
Cohesion (range 10 to 50)	37.3	(7.0)	41	38.6	(5.2)	34	.38	.19	37.5	(7.2)	36	38.5	(5.2)	33	.50	.14
• Family Resource Scale[♦] (FRS) (range 30 to 150)	118.8	(14.8)	41	116.3	(19.5)	34	.52	-.17	119.7	(14.5)	36	116.3	(19.8)	33	.42	-.23
• Family Support Scale[δ] (FSS) Total Score (range 0 to 4)	1.8	(0.7)	40	2.2	(0.8)	33	.06	.57	1.9	(0.7)	35	2.2	(0.8)	32	.19	.43
• Peabody Picture Vocabulary[′] Test - Revised (PPVT)	83.3	(18.1)	40	92.3	(18.3)	34	.04	.50	83.2	(19.1)	35	93.6	(16.9)	33	.02	.54

(continued)

[*] Statistical analyses for BDI scores were conducted using raw scores for each of the scales, and these are presented.

[◆] Scores for each subscale of the FACES are based on linear scoring where high scores are preferred.

[♦] Analysis of the FRS is based on raw scores indicating the number of resources reported by the family as being available. Higher scores are considered better.

[♦] Analysis for the PSI and FILE are based on raw scores. Lower scores are considered better.

[δ] Analysis for the FSS is based on the sum of the perceived support score divided by the number of sources of support available. Higher scores are considered better.

[′] Analysis for the PPVT are based on standard scores. Although this measure was obtained at posttest, it addresses comparability and is presented here.

$$ES = \frac{\bar{x}\text{ (Classroom + PIE)} - x\text{ (Classroom only)}}{\text{SD (Classroom Only)}}$$

The sign of the ES is reversed for the PSI, as lower scores are preferred.

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Table 8.15 (continued)

Comparability of Groups on Pretest Measures for Des Moines Parent Involvement Study

	Reassessment #3								Reassessment #4							
	Classroom-Only			Classroom + PIE					Classroom-Only			Classroom + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES
• Battelle Developmental[·] Inventory (BDI)																
Personal/Social	108.4	(29.0)	37	106.5	(24.0)	31	.77	-.07	108.4	(29.0)	37	106.3	(23.4)	34	.74	-.07
Adaptive Behavior	71.6	(16.0)	37	65.7	(17.0)	31	.14	-.37	71.6	(16.0)	37	65.1	(16.8)	34	.10	-.41
Motor	100.7	(22.8)	37	92.0	(27.8)	31	.16	-.38	100.7	(22.8)	37	92.5	(27.0)	34	.17	-.36
Communication	52.1	(15.7)	37	50.7	(19.7)	31	.76	-.09	52.1	(15.7)	37	50.1	(19.0)	34	.67	-.13
Cognitive	42.7	(14.6)	37	43.5	(18.3)	31	.84	.05	42.7	(14.6)	37	43.0	(17.8)	34	.94	.02
TOTAL	375.5	(87.5)	37	358.5	(96.3)	31	.45	-.19	375.5	(87.5)	37	357.2	(93.1)	34	.40	-.00
• Parenting Stress Index (PSI)[◆]																
Child Related (range 0 to 30)	118.2	(20.7)	36	118.1	(18.7)	31	.98	.00	118.2	(20.7)	36	117.4	(18.4)	34	.86	.04
Other Related (range 54 to 270)	129.6	(23.0)	36	134.4	(28.0)	31	.44	-.21	129.6	(23.0)	36	131.6	(28.8)	34	.75	-.09
• Family Adaptability and Cohesion Evaluation Scales (FACES)[◆]																
Adaptation (range 10 to 50)	21.9	(7.0)	36	22.0	(3.8)	31	.92	.01	21.9	(7.0)	36	21.9	(3.7)	34	.98	.00
Cohesion (range 10 to 50)	37.5	(7.3)	36	38.2	(5.2)	31	.64	.10	37.5	(7.3)	36	38.6	(5.2)	34	.45	.15
• Family Resource Scale[◆] (FRS) (range 30 to 150)	119.0	(14.1)	36	116.0	(19.5)	31	.47	-.21	119.0	(14.1)	36	116.3	(19.5)	34	.50	-.19
• Family Support Scale[δ] (FSS) Total Score (range 0 to 4)	1.9	(0.7)	35	2.2	(0.8)	30	.11	.43	1.9	(.7)	35	2.2	(.8)	33	.12	.43
• Peabody Picture Vocabulary[·] Test - Revised (PPVT)	82.6	(18.9)	35	93.7	(14.8)	31	.01	.59	82.6	(18.9)	35	92.3	(18.3)	34	.03	.51

(continued)

[·] Statistical analyses for BDI scores were conducted using raw scores for each of the scales, and these are presented.

[◆] Scores for each subscale of the FACES are based on linear scoring where high scores are preferred.

[◆] Analysis of the FRS is based on raw scores indicating the number of resources reported by the family as being available. Higher scores are considered better.

[◆] Analysis for the PSI and FILE are based on raw scores. Lower scores are considered better.

[δ] Analysis for the FSS is based on the sum of the perceived support score divided by the number of sources of support available. Higher scores are considered better.

[·] Analysis for the PPVT are based on standard scores. Although this measure was obtained at posttest, it addresses comparability and is presented here.

$$ES = \frac{\bar{x}\ (\text{Classroom + PIE}) - x\ (\text{Classroom only})}{SD\ (\text{Classroom Only})}$$

The sign of the ES is reversed for the PSI, as lower scores are preferred.

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Table 8.15 (continued)

Comparability of Groups on Pretest Measures for Des Moines Parent Involvement Study

	Reassessment #5							
	Classroom-Only			Classroom + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES[♦]
• Battelle Developmental Inventory[*] (BDI)								
Personal/Social	108.9	(28.7)	38	110.0	(30.4)	33	.89	.04
Adaptive Behavior	71.3	(15.5)	38	65.6	(16.9)	33	.14	-.37
Motor	100.5	(22.3)	38	92.7	(27.4)	33	.19	-.35
Communication	51.5	(15.2)	38	50.4	(19.4)	33	.79	-.07
Cognitive	42.5	(14.3)	38	43.2	(18.0)	33	.86	.05
TOTAL	374.7	(85.5)	38	358.8	(94.1)	33	.46	-.19
• Parenting Stress Index[']								
Child Related (range 0 to 30)	118.6	(20.5)	37	117.1	(18.7)	33	.75	.07
Other Related (range 54 to 270)	130.4	(23.1)	37	131.7	(29.2)	33	.83	-.06
• Family Adaptability and Cohesion[♣] Evaluation Scales (FACES)								
Adaptation (range 10 to 50)	22.3	(6.8)	37	21.9	(3.7)	33	.78	-.06
Cohesion (range 10 to 50)	37.9	(7.0)	37	38.8	(5.2)	33	.54	.13
• Family Resource Scale (FRS)[*] (range 30 to 150)	118.8	(13.8)	37	115.9	(19.6)	33	.48	-.21
• Family Support Scale (FSS)['] Total Score (range 0 to 4)	1.9	(.6)	36	2.2	(.8)	32	.13	.50
• Peabody Picture Vocabulary['] Test--Revised (PPVT)	83.5	(18.9)	36	92.4	(18.6)	33	.05	.47

[*] Statistical analyses for BDI scores were conducted using raw scores for each of the scales, and these are presented.

[♣] Scores for each subscale of the FACES are based on linear scoring where high scores are preferred.

[♦] Analysis of the FRS is based on raw scores indicating the number of resources reported by the family as being available. Higher scores are considered better.

[♦] Analysis for the PSI and FILE are based on raw scores. Lower scores are considered better.

['] Analysis for the FSS is based on the sum of the perceived support score divided by the number of sources of support available. Higher scores are considered better.

['] Analysis for the PPVT are based on standard scores. Although this measure was obtained at posttest, it addresses comparability and is presented here.

$$ES = \frac{\bar{x}\text{ (Classroom + PIE)} - \bar{x}\text{ (Classroom only)}}{\text{SD (Classroom Only)}}$$

Sign of the ES is reversed for the PSI, as lower scores are preferred

Table 8.15 (continued)

Comparability of Groups on Pretest Measures for Des Moines Parent Involvement Study

	Reassessment #6							
	Classroom-Only			Classroom + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES◆
• Battelle Developmental Inventory• (BDI)								
Personal/Social	108.4	(28.8)	37	110.6	(30.6)	32	.75	.08
Adaptive Behavior	71.0	(15.6)	37	71.0	(17.1)	32	.96	.00
Motor	100.2	(22.5)	37	93.5	(27.8)	32	.22	-.30
Communication	51.0	(15.1)	37	50.7	(19.6)	32	.93	-.02
Cognitive	42.2	(14.4)	37	43.4	(18.3)	32	.76	.08
TOTAL	372.7	(85.8)	37	359.4	(95.5)	32	.55	-.16
• Parenting Stress Index•								
Child Related (range 0 to 30)	118.2	(20.4)	37	116.5	(18.6)	32	.71	.08
Other Related (range 54 to 270)	130.1	(23.4)	37	131.2	(29.5)	32	.87	-.05
• Family Adaptability and Cohesion◆ Evaluation Scales (FACES)								
Adaptation (range 10 to 50)	22.5	(6.7)	36	22.0	(3.7)	32	.72	.07
Cohesion (range 10 to 50)	37.8	(7.1)	36	38.7	(5.2)	32	.57	.13
• Family Resource Scale (FRS)• (range 30 to 150)	118.9	(14.0)	36	115.8	(20.0)	.32	-.52	-.22
• Family Support Scale (FSS)1.9 Total Score (range 0 to 4)	(0.66)	35	2.2	(.78)	31	.31	.42	.45
• Peabody Picture Vocabulary Test--Revised (PPVT)	83.6	(19.2)	35	92.5	(18.9)	32	.06	.46

(continued)

• Statistical analyses for BDI scores were conducted using raw scores for each of the scales, and these are presented.

◆ Scores for each subscale of the FACES are based on linear scoring where high scores are preferred.

◆ Analysis of the FRS is based on raw scores indicating the number of resources reported by the family as being available. Higher scores are considered better.

◆ Analysis for the PSI and FILE are based on raw scores. Lower scores are considered better.

• Analysis for the FSS is based on the sum of the perceived support score divided by the number of sources of support available. Higher scores are considered better.

• Analysis for the PPVT are based on standard scores. Although this measure was obtained at posttest, it addresses comparability and is presented here.

$ES = \frac{\bar{x}\text{ (Classroom + PIE)} - x\text{ (Classroom only)}}{\text{SD (Classroom Only)}}$ Sign of the ES is reversed for the PSI, as lower scores are preferred

Table 8.15 (continued)

Comparability of Groups on Pretest Measures for Des Moines Parent Involvement Study

	Reassessment #7							
	Classroom-Only			Classroom + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES$^{\blacklozenge}$
• Battelle Developmental Inventory* (BDI)								
Personal/Social	108.4	(28.8)	37	110.0	(30.4)	33	.82	.06
Adaptive	71.0	(15.6)	37	65.6	(16.9)	33	.17	-.35
Motor	100.2	(22.5)	37	92.7	(27.4)	33	.22	-.33
Communication	51.0	(15.1)	37	50.4	(19.4)	33	.88	-.04
Cognitive	42.2	(14.4)	37	43.2	(18.0)	33	.80	.07
Total	372.7	(85.8)	37	358.8	(94.1)	33	.52	-.16
• Parenting Stress Index								
Child Related	118.2	(20.4)	37	117.1	(18.7)	33	.81	.05
Other Related	130.1	(23.4)	37	131.7	(29.2)	33	.81	.07
• Family Adaptability and Cohesion								
Adaptation	22.5	(6.7)	36	21.9	(3.7)	33	.65	-.09
Cohesion	37.8	(7.1)	36	38.8	(5.2)	33	.52	.14
• Family Resource Scale	118.9	(14.0)	36	115.9	(19.6)	33	.48	-.21
• Family Support Scale	1.9	(.7)	35	2.2	(.8)	32	.12	.43
• Peabody Picture Vocabulary Test (PPVT)	83.6	(19.2)	35	92.4	(18.6)	33	.06	.46

(see notes on previous page)

Of the family measures at Reassessment #1, significant differences were found between the groups only on the FSS. Scores from the Family Support Scale indicate that families in the Classroom + PIE group had more support. Although the families differed on this measure, their stress ratings (based on the PSI) were not different. Also, resources available to each family (FRS), and family adaptability and cohesion (FACES) by group were comparable. Current knowledge of family functioning makes it difficult to interpret the effect that this pretest family functioning results profile may have on subject or family functioning as a result of intervention. However, because there is no correlation between the pretest scores on the FSS and measures of child functioning at the reassessments, these initial differences on the FSS are very unlikely to have biased child outcomes. FSS test scores, some demographic measures (e.g., mother education), and other family measures do correlate with each other. Therefore, the FSS was considered as a potential covariate for later analyses.

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Also included on Table 8.15 are scores from mother's performance on the Peabody Picture Vocabulary Test. This result is not an outcome variable, even though obtained at reassessment. These data are related to the comparability of groups. A significant difference was found between mother's standard scores on this test, with mothers in the Classroom + PIE group demonstrating higher scores. Standard scores on this test are highly correlated with IQ scores. Mother's IQ has been hypothesized to be related to intervention success. PPVT scores were considered as a covariate for all later analyses.

Overall, these results suggest that any group advantages at pretest favored the Classroom + PIE group on demographic and family functioning variables. However, child functioning variables favor the Classroom-Only group.

The pattern of results found for comparability of groups at Reassessment #1 is essentially the same for Reassessment #2 - #7 (see Tables 8.1 and 8.15). Although there are minor changes from one to another, the general pattern is one of comparability between the groups. What few differences do exist primarily favor the Classroom + PIE group on demographic variables and on maternal IQ. Random assignment to groups does not guarantee group comparability (cf., Shaver, 1993), especially when a large number of variables are examined for comparability. However, the comparability information does allow for a detailed description of the subjects (children and families) in each group. As Shaver (1993) has noted, this type of detailed information is crucial to assist readers in making (or not making) generalizations. Also, as noted earlier, variables where differences were discovered were considered in selecting covariates for the analysis of differences between groups at reassessments.

Effects of Alternative Forms of Intervention

The following section will analyze the effects of the alternative forms of intervention on child and family functioning, and examine some site specific analyses.

Selection of covariates. The majority of analyses presented in this section are based on analysis of covariance procedures completed using SPSS-PC. Treatment group served as the independent variable, and dependent variables were scores obtained from the assessment instruments described earlier. (Analyses other than analyses of covariance are described as such in the text and/or table.) Cautions have been raised regarding the use of analysis of covariance procedures (Thompson, 1992). However, once these cautions are considered, analysis of covariance can be a useful technique. Analysis of covariance procedures are primarily useful for two purposes (Taylor & Innocenti, 1993): (a) to increase the statistical power of a study by reducing error variance, and (b) to adjust for any pretreatment differences which are present between the groups. In either application, the degree to which analysis of covariance is useful depends on the correlation between the covariate(s) selected and the outcome variable for which analyses are being done. However, since one degree of freedom is lost for each covariate used, it is generally best to use a limited number of covariates in any given analysis. In addition, the covariate must be interpretable, must be reliable, and must meet the homogeneity of regression assumption.

All pretest and demographic variables and variables that could impact on treatment were considered as potential covariates. The final selection of covariates depended on a judgment of which variable or set of variables could be used to maximize the correlation or multiple correlation with the outcome variable in question and still include those demographic or pretest variables for which there were the largest pretreatment differences, and meet the assumptions noted above. In each analysis, the specific covariates used are indicated in the table.

Although sample sizes for this study are as large or larger than previous early intervention studies with these types of children, the statistical power of the analysis is still a concern. According to Hopkins (1973) and Cohen (1977), in those cases where a covariate or set of covariates can be found which correlates with the dependent variable (which was almost always the case in these analyses), analysis of covariance can substantially increase power. In this study, with alpha set at $p \leq .10$, statistical power for finding a moderately sized difference (defined by Cohen as differences of a half a standard deviation) at Reassessment #1 was approximately 92% for child outcome measures and approximately 86% for the majority of family outcome variables. Power for the PAAT, CES-D, and Child Improvement Questionnaire was approximately 80%. A small decrement in statistical power occurs at each successive reassessment as correlations between pretest and outcome variables slightly decrease. (See Taylor & Innocenti, 1993, for a formula for estimating power when using analysis of covariance procedures.)

Measures of Child Functioning

Results of reassessment data analysis on child functioning for Reassessments #1-#3 are presented in Table 8.16, and for Reassessments #4-#7 in Table 8.17.

Reassessment #1. After one year of intervention, results from the BDI showed a statistically significant difference ($p < .10$) on the communication domain in favor of the Classroom + PIE group. Statistically significant differences were not found on other domains, nor on the Total BDI score. Statistically significant differences were not found on the Joseph Preschool and Primary Self-Concept Inventory (JSI) nor on the Stanford-Binet. These results suggest that the addition of this type of parent involvement program had some impact on measures of child development, but the impact was not consistent across the various domains measured. All but one of the effect sizes were positive.

Reassessment #2. Results from Reassessment #2 are also presented in Table 8.16. Information on the Stanford-Binet is not included for this analysis since it was not administered after the 1986-87 academic year. As mentioned earlier, Reassessment #2 analyses include subjects who "graduated" to school-age programs as well as those who received two consecutive years of intervention. No group differences were found on any of the BDI domains or total score. Results from the JSI also indicate no group

Table 8.16

Reassessment Measures of Child Functioning for Reassessment #1, #2, and #3 for Des Moines Parent Involvement Study

Variable	Covariates•	Classroom Only				Classroom + PIE				ANCOVA F	P Value	ES^
		$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n			
Reassessment #1												
Age in months at posttest'	---	59.9	(11.7)		42	59.3	(11.6)		34	.05	.82	-.05
Battelle developmental Inventory' (BDI)												
Personal/Social	1	118.2	(24.6)	115.0	42	116.1	(24.9)	119.3	34	.99	.32	.17
Adaptive Behavior	1	75.0	(15.0)	72.4	42	72.9	(20.9)	75.5	34	1.48	.23	.21
Motor	1	112.4	(23.4)	108.0	42	102.4	(28.6)	106.9	34	.09	[illegible]	-.05
Communication	1	58.4	(16.0)	55.3	42	57.9	(21.1)	61.0	34	4.11	.05	.36
Cognitive	1	51.9	(16.4)	49.1	42	49.0	(17.9)	51.8	34	.95	.33	.16
TOTAL	1	415.9	(82.9)	398.5	42	398.4	(103.9)	415.7	34	2.37	.13	.21
Stanford-Binet'	1	75.6	(18.8)	73.3	28	72.1	(15.9)	74.4	19	.06	.81	.06
Joseph Preschool Primary' Self-Concept Inventory	2	19.5	(5.8)	19.2	11	20.9	(4.1)	21.2	7	1.57	.23	.34
Reassessment #2												
Age in months at posttest	---	70.9	(12.2)		37	71.6	(12.5)		33	.07	.80	.06
Battelle developmental Inventory' (BDI)												
Personal/Social	1	132.8	(25.4)	129.9	37	128.5	(32.6)	131.4	33	.08	.78	.06
Adaptive Behavior	1	89.3	(18.0)	87.1	37	84.5	(20.1)	86.8	33	.02	.90	-.03
Motor	1	120.9	(24.8)	117.8	37	111.6	(32.9)	114.6	33	.41	.53	-.13
Communication	1	68.0	(18.9)	65.9	37	66.6	(23.2)	68.7	33	.51	.48	.15
Cognitive	1	65.7	(23.0)	63.2	37	64.9	(25.4)	67.4	33	.99	.32	.18
TOTAL	1	476.7	(97.7)	464.0	37	456.0	(124.5)	468.8	33	.08	.78	.05
Joseph Preschool Primary' Self-Concept Inventory	3	22.2	(6.4)	22.1	32	23.7	(4.3)	23.8	29	1.87	.18	.27
Reassessment #3												
Age in months at posttest	---	83.8	(12.1)		37	83.7	(11.7)		31	.00	.98	.01
Battelle developmental Inventory' (BDI)												
Personal/Social	1	146.4	(17.2)	144.2	37	143.8	(27.7)	146.0	31	.16	.69	.10
Adaptive Behavior	1	97.5	(15.5)	94.9	37	94.3	(21.3)	97.0	31	.55	.46	.14
Motor	1	130.4	(23.1)	127.3	37	121.7	(33.1)	124.7	31	.27	.61	-.11
Communication	1	77.7	(20.9)	75.5	37	76.1	(25.2)	78.3	31	.41	.53	.13
Cognitive	1	75.0	(22.8)	72.4	37	73.3	(25.8)	75.8	31	.59	.45	.15
TOTAL	1	526.9	(88.9)	514.8	37	509.1	(125.0)	521.2	31	.12	.73	.07
Joseph Preschool Primary' Self-Concept Inventory	---	23.3	(4.4)	23.3	31	25.0	(3.5)	25.0	24	2.35	.13	.39

' Statistical analysis for BDI and JSI were conducted using raw scores for each of the scales and these are presented.

^ Effect Size (ES) is defined here as the difference between the groups (Classroom + PIE minus Classroom Only) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation of the Classroom Only Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977 for a more general discussion of the concept of Effect Size).

• Covariates: 1 = BDI adaptive; 2 = BDI motor; 3 = BDI Total; 4 = PSI Total; 5 = PSI Child; 6 = PSI other; 7 = FACES Total; 8 = FACES Discrepancy; 9 = FSS Total; 10 = FRS Total; 11 = FILE Total; 12 = PPVT Standard Score; 13 = Income; 14 = Mother Education; 15 = Hours of Daycare; 16 = Battelle Communication; 17 = Battelle Cognitive; 18 = Mothers Age; 19 = Adaptation; 20 = Cohesion; 21 = Siblings in home; 22 = FACES Perceived raw score; 23 = Ethnicity of child; 24 = FSS Total Support; 25 = Age of child at pretest; 26 = BDI Personal-Social; 27 = Ethnicity of Mother; 28 = Primary caretaker; 29 = Sex of child; 30 = Mother living with child

' Statistical analysis for the Stanford-Binet were conducted using IQ scores.

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Table 8.17

Reassessments #4 - #7 Measures of Child Functioning for the Des Moines Parent Involvement Study

		Classroom Only				Classroom + PIE						
Variable	Covariates*	x̄	(SD)	Adj.x̄	n	x̄	(SD)	Adj.x̄	n	ANCOVA F	P Value	ES^
REASSESSMENT #4												
Age in months at reassessment	---	96.3	(12.7)	---	37	97.0	(11.8)	---	34	.06	.80	.06
Woodcock-Johnson Test of Achiev.												
Broad Knowledge	3	461.7	(19.4)	459.9	37	458.5	(27.4)	460.3	34	.01	.91	.02
Skills	3	422.3	(38.4)	418.8	37	416.7	(50.6)	420.2	34	.04	.83	.04
Scales of Independent Beh.												
Motor Skills	2	462.8	(22.3)	458.4	37	455.0	(40.7)	459.4	34	.04	.84	.04
Social/Communication	3	465.0	(14.9)	463.6	37	463.9	(20.8)	465.3	34	.40	.53	.11
Personal Living	2	471.4	(17.3)	468.5	37	466.9	(25.8)	469.7	34	.13	.72	.07
Community Living	3	443.4	(24.0)	441.4	37	443.6	(26.8)	445.6	34	1.18	.28	.18
Broad Independence	2	461.0	(17.3)	457.9	37	457.4	(27.1)	460.5	34	.71	.40	.15
Joseph Total	26	24.8	(5.0)	24.8	30	25.0	(3.6)	25.1	27	.06	.82	.06
REASSESSMENT #5												
Age in months at reassessment		108.6	(11.6)		38	109.1	(12.1)		33	.04	.85	.04
Woodcock-Johnson Test of Achiev.												
Broad Knowledge	3	469.0	(19.3)	467.6	38	465.5	(25.8)	467.0	33	.03	.87	-.03
Skills	3	435.6	(40.6)	432.8	38	431.2	(48.9)	434.0	33	.03	.87	.03
Scales of Independent Beh.												
Motor Skills	2	466.9	(22.3)	463.1	38	456.1	(38.1)	459.9	33	.05	.48	-.14
Social/Communication	3	468.7	(13.6)	467.8	38	467.5	(17.3)	468.5	33	.07	.80	.05
Personal Living	2	477.4	(15.0)	475.0	38	470.0	(24.9)	472.4	33	.64	.43	-.17
Community Living	3	454.2	(25.8)	452.7	38	451.3	(24.6)	452.8	33	.00	.97	.00
Broad Independence	2	466.9	(16.8)	464.4	38	461.3	(24.6)	463.8	33	.04	.84	-.04
Pictorial Perceived Competence and Social Acceptance												
Cognitive Competency	5	20.7	(2.1)	20.7	31	21.0	(2.0)	21.0	25	.21	.65	.14
Peer Acceptance	31	16.3	(4.0)	16.1	32	17.9	(5.3)	18.0	25	2.41	.13	.40
Physical Competency	31	19.1	(3.3)	18.9	32	20.4	(2.9)	20.6	25	4.71	.03	.55
Maternal Acceptance	18	16.0	(3.9)	15.8	30	16.9	(3.8)	17.0	24	1.12	.30	.31
Parent Social Skills Rating Scale												
Skill Total	26	88.0	(15.3)	88.3	36	89.4	(16.0)	89.1	31	.05	.82	.05
Problem Behaviors	1	118.2	(62.8)	117.0	38	101.1	(18.2)	102.3	31	1.57	.22	.23
REASSESSMENT #6												
Age in months at reassessment	---	120.3	(12.0)	---	37	121.8	(12.0)	---	32	---	.61	.1
Woodcock-Johnson Test of Achiev.												
Broad Knowledge	3	473.9	(20.3)	472.6	37	469.8	(28.1)	471.1	32	0.14	.71	-.07
Skills	3	445.9	(39.0)	443.4	37	441.2	(55.9)	443.6	32	0.00	.99	.01
Scales of Independent Beh.												
Motor Skills	2	472.2	(18.4)	469.2	37	460.1	(39.4)	463.4	31	1.36	.25	-.32
Social/Communication	3	473.1	(13.8)	472.3	37	468.9	(19.2)	469.8	31	0.77	.39	-.18
Personal Living	2	480.5	(13.8)	478.6	37	472.9	(26.1)	475.1	31	0.90	.35	-.25
Community Living	3	459.3	(23.4)	458.0	37	455.4	(27.3)	456.7	31	0.09	.77	-.06
Broad Independence	2	471.5	(15.3)	469.4	37	464.5	(26.2)	466.8	31	0.50	.48	-.17
Pictorial Scale of Perceived Competence & Social Acceptance												
Cognitive Competency	5	20.9	(2.7)	20.8	30	20.7	(2.2)	20.7	21	0.02	.89	-.04
Peer Acceptance	31	17.9	(3.8)	18.0	30	16.6	(4.9)	16.6	21	1.26	.27	-.37
Physical Competency	31	20.3	(3.5)	20.4	30	20.8	(2.2)	20.8	21	0.29	.60	.11
Maternal Acceptance	18	15.7	(4.2)	15.7	30	17.4	(4.1)	17.2	21	0.87	.36	.36
Parent Social Skills Rating Scale												
Skill Total	32	89.1	(21.5)	89.4	35	90.4	(16.7)	90.2	28	0.04	.83	.04
Problem Behaviors	5	105.6	(14.4)	105.6	35	110.3	(12.6)	110.2	28	2.22	.14	.32

(continued)

Statistical analysis were conducted using weighted raw scores for the Woodcock-Johnson and for the Scales of Independent Behavior. Standard scores were used for analysis on both Social Skill Rating Scales. Raw scores were used for analysis on all other measures.

$$ES = \frac{\text{Adj.}\bar{x}\ (\text{Classroom + PIE}) - \text{Adj.}x\ (\text{Classroom-Only})}{\text{SD (Classroom-Only)}}$$

* Covariates: 1 = BDI adaptive; 2 = BDI motor; 3 = BDI Total; 4 = PSI Total; 5 = PSI Child; 6 = PSI other; 7 = FACES Total; 8 = FACES Discrepancy; 9 = FSS Total; 10 = FRS Total; 11 = FILE Total; 12 = PPVT Standard Score; 13 = Income; 14 = Mother Education; 15 = Hours of Daycare; 16 = Battelle Communication; 17 = Battelle Cognitive; 18 = Mothers Age; 19 = Adaptation; 20 = Cohesion; 21 = Siblings in home; 22 = FACES Perceived raw score; 23 = Ethnicity of child; 24 = FSS Total Support; 25 = Age of child at pretest; 26 = BDI Personal-Social; 27 = Ethnicity of Mother; 28 = Primary caretaker; 29 = Sex of child; 30 = Mother living with child; 31 = Battelle Gross Motor

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Table 8.17 (continued)

Reassessments #4 - #7 Measures of Child Functioning for the Des Moines Parent Involvement Study

		Classroom Only				Classroom + PIE						
Variable	Covariates*	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	P Value	ES'
REASSESSMENT #7												
Age in months at reassessment	---	132.4	(11.8)	---	37	133.5	(12.1)	---	33	---	.70	.09
Woodcock-Johnson												
Broad Knowledge	1	479.5	(19.9)	478.3	37	476.0	(27.7)	477.2	33	0.06	.81	-.06
Skills	1	453.8	(39.6)	451.5	37	452.6	(49.4)	454.9	33	0.18	.68	.09
SIB												
Motor Skills	2	477.0	(19.6)	473.5	37	464.6	(39.0)	468.1	33	1.30	.26	-.28
Social/Comm.	1	474.4	(17.3)	473.5	37	474.6	(22.6)	475.6	33	0.32	.57	.12
Personal Living	2	484.1	(16.0)	481.6	37	478.6	(27.8)	481.1	33	0.02	.89	-.03
Community Living	1	463.1	(23.8)	461.7	37	463.5	(28.7)	464.9	33	0.51	.48	.13
Broad Independence	2	475.2	(17.0)	472.7	37	468.9	(28.5)	471.4	33	0.11	.74	-.08
Pictorial Scale of Perceived Competence & Social Acceptance												
Cognitive Compt.	9	20.8	(2.8)	20.8	34	21.0	(2.6)	21.0	24	0.08	.77	.07
Peer Acceptance	6	17.9	(4.4)	17.9	34	17.9	(4.9)	17.9	24	0.00	.99	.00
Physical Compt.	6	20.9	(3.2)	20.9	34	20.5	(2.8)	20.4	24	0.46	.50	-.16
Maternal Accept.	7	15.7	(4.0)	16.1	34	16.5	(5.4)	16.0	24	0.01	.93	-.03
Parent Social Skills Rating Scale												
Skill Total	8	91.1	(17.3)	91.4	36	92.6	(19.9)	92.3	31	0.04	.84	.05
Problem Behaviors	9	106.1	(16.5)	105.8	36	106.8	(13.7)	107.0	31	0.12	.73	-.07

* Covariates: 1 = Battelle Total Raw Score; 2 = Battelle Motor Raw Score; 3 = PSI Other, 4 = PSI Total; 5 = FSS Ratio; 6 = Battelle Gross Motor Raw Score, 7 = Mother's Age at Pretest, 8 = Battelle Cognitive Raw Score; 9 = PSI Child.

differences (however, note the difference in the JSI sample between Reassessments #1 and #2). Data indicate that any positive effects of the parent involvement were not maintained over time or may have been the result of sampling fluctuation. These data may have been effected by the implementation of the PIE II curriculum for some parents. These effects will be examined in analyses presented later in this report.

Reassessment #3. Table 8.16 also includes child measure results from Reassessment #3. No group differences were found on the BDI or JSI.

Reassessment #4. Results from Reassessment #4 are presented in Table 8.17. The child measures used at this reassessment represent an entirely different instrument battery. However, the results are consistent with the findings of Reassessments #2 and #3. No statistically significant differences were found between groups on the Woodcock-Johnson Tests of Achievement, on the Scales of Independent Behavior, nor on the JSI.

Reassessment #5. Results from Reassessment #5 are also presented in Table 8.17. In addition to the Woodcock-Johnson and SIB, data are presented from the Pictorial Scale of Perceived Competence and Social Acceptance (referred to hereafter as the Harter Scales) (which replaced the JSI). The parent-rated version of the Social Skills Rating Scale was included to examine child social skills and problem behaviors. The results of these analyses are consistent with findings from earlier reassessments. No statistically significant differences were found on the majority of measures. A statistically significant difference was found on the Physical Competency Scale of the Harter Scales indicating that children in the Classroom + PIE group perceived themselves as more physically competent than the children in the Classroom-Only group.

Reassessment #6 and #7. The results of reassessment #6 and #7 are consistent with the earlier findings on the Woodcock-Johnson, SIB, and parent completed Social Skills Rating Scale (Table 8.17). No statistically significant differences were found on the Harter Scales.

Measures of Family Functioning

Table 8.18 presents data on parent and family functioning for Reassessments #1 - #7.

Reassessment #1. Families in the Classroom + PIE group were found to have more sources of support available to them based on scores from the Family Support Scale. It is possible that the support component of the PIE influenced perceived social support. A significant difference was also found on the CES-D. Mothers in the Classroom + PIE group reported statistically significantly less depression symptamology than the Classroom-Only group mothers.

Table 8.18

Reassessment Measures of Family Functioning for Des Moines Study

		Reassessment #1													**Reassessment #2**												
		Classroom Only					Classroom + PIE								Classroom Only										Classroom + PIE		
Variable	Covariates°	$\bar{x}$	(SD)	Adj.$\bar{x}$	%ile	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	%ile	n	ANCOVA F	P Value	ES	$\bar{x}$	(SD)	Adj.$\bar{x}$	%ile	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	%ile	n	ANCOVA F	P Value	ES
Parent Stress Index (PSI)*																											
Child Related	5	118.2	(21.7)	117.3	86	41	112.8	(16.5)	113.7	80	34	1.32	.25	.17	119.0	(20.7)	118.8	88	35	118.5	(17.0)	118.6	88	32	.00	.96	.01
Other Related	6	134.5	(24.1)	134.2	72	41	129.6	(26.2)	129.9	66	34	1.85	.18	.18	129.2	(20.1)	130.4	66	35	133.2	(28.0)	131.9	70	32	.14	.71	-.07
TOTAL	4	252.7	(39.8)	251.4	81	41	242.4	(38.1)	243.6	75	34	2.32	.13	.20	248.2	(35.5)	249.2	79	35	251.6	(39.6)	250.6	81	32	.05	.82	-.04
Family Support Scale (FSS)♦♦																											
TOTAL	9	1.5	(.8)	1.6		39	2.1	(.6)	2.0		34	8.34	.01	.50	1.7	(.8)	1.8		23	2.1	(.9)	2.0		24	.60	.44	.25
Family Adaptation' Cohesion Eval. (FACES)																											
Adaptation	19	21.4	(6.7)	21.5		40	20.8	(4.9)	20.7		33	.45	.51	-.09	21.2	(5.4)	21.2		34	20.3	(5.2)	20.3		32	.56	.46	-.17
Cohesion	20	38.0	(7.0)	38.4		40	38.1	(6.0)	37.7		33	.30	.59	.01	36.6	(7.2)	36.9		34	36.9	(6.9)	36.6		32	.04	.85	.04
Child Improvement'' (Locus of Control)																											
Professional	18	18.7	(2.8)	18.9		41	19.9	(4.3)	19.6		34	.75	.39	.25	19.9	(4.5)	20.1		36	19.3	(3.8)	19.1		32	.94	.34	-.22
Divine Intervention	14	12.4	(3.3)	12.2		41	11.4	(3.5)	11.8		34	.30	.59	-.04	11.5	(3.4)	11.2		36	11.6	(3.6)	11.8		32'	.50	.48	.18
Parent	5	23.4	(2.5)	23.4		41	23.9	(3.1)	23.9		34	.90	.35	.20	23.8	(2.8)	23.8		36	23.9	(3.2)	23.9		32	.02	.88	.04
Child	12	21.3	(3.0)	21.0		41	19.8	(4.2)	20.1		34	1.26	.27	.30	21.9	(4.0)	21.4		36	19.4	(3.8)	19.9		32	2.97	.10	-.38
Chance	12	11.6	(3.7)	11.3		41	9.3	(3.1)	9.6		34	5.05	.03	-.46	12.7	(4.6)	12.7		36	9.7	(3.2)	9.7		32	4.01	.05	-.65
CES-D Depression*	6	31.6	(9.0)	31.5		41	28.4	(8.6)	28.4		34	2.88	.09	.34	29.1	(6.7)	29.4		36	33.8	(12.0)	33.5		33	4.37	.04	-.61
Parent as a Teacher♦ Scale (PAAT)																											
Creativity	5														26.7	(1.6)	26.7		34	27.0	(2.7)	27.0		32	.31	.58	.19
Frustration	4														27.0	(2.1)	27.0		34	26.7	(3.1)	26.7		32	.23	.63	-.14
Control	3														25.7	(2.7)	25.8		34	27.0	(2.6)	26.9		32	3.27	.08	.40
Play	4														28.9	(2.5)	28.8		34	29.3	(2.9)	29.3		32	.65	.43	.20
Teaching/Learning	5														28.7	(2.7)	28.7		34	29.7	(3.0)	29.7		32	2.59	.11	.37
TOTAL	4														137.0	(8.3)	136.9		34	139.7	(11.5)	139.8		32	1.63	.21	.35

(continued)

Effect Size (ES) is defined here as the difference between the groups (Classroom + PIE minus Classroom Only) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation of the Classroom Only Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977, for a more general discussion of the concept of Effect Size). For the PSI and CES-D, the numerator for the ES is reversed, as lower scores are preferred.

* Statistical analysis for the PSI and CES-D were based on raw scores where low raw scores are most desirable.

' Scores for each subscale of the FACES are derived from linier scoring where higher scores are preferred.

♦ Statistical analyses for the FRS and PAAT were based on raw scores where higher scores are preferred.

♦♦ Analyses for the FSS is based on the sum of the preferred support scored divided by the number of scores of support available. Higher scores are preferred.

° Covariates: 1 = BDI adaptive; 2 = BDI motor; 3 = BDI Total; 4 = PSI Total; 5 = PSI Child; 6 = PSI other; 9 = FSS Total; 10 = FRS Total; 11 = FILE Total; 12 = PPVT Standard Score; 13 = Income; 14 = Mother Education; 15 = Hours of Daycare; 16 = Battelle Communication; 17 = Battelle Cognitive; 18 = Mothers Age; 19 = Adaptation; 20 = Cohesion; 21 = Siblings in home; 22 = FACES Perceived raw score; 23 = Ethnicity of child; 24 = FSS Total Support; 25 = Age of child at pretest; 26 = BDI Personal-Social; 27 = Ethnicity of Mother; 28 = Primary caretaker; 29 = Sex of child; 30 = Mother living with child; 31 = FSS sources of support; 32 = father education. Covariate numbers in standard type were used for both Reassessment #1 and #2, **bold** numbers were used for Reassessment #1 only, underlined numbers were used for Reassessment #2 only.

'' On the Child Improvement Questionnaire, ESs are used only to indicate direction of result. See text for interpretation of findings. Statistical analyses are based on raw scores.

Table 8.18 (continued)

Reassessment Measures of Family Functioning for Des Moines Study

		Reassessment #3													Reassessment #4													
		Classroom Only					Classroom + PIE								Classroom Only										Classroom + PIE			
Variable	Covariates[•]	x̄	(SD)	Adj. x̄	%ile	n	x̄	(SD)	Adj. x̄	%ile	n	ANCOVA F	P Value	ES	x̄	(SD)	Adj. x̄	%ile	n	x̄	(SD)	Adj. x̄	%ile	n	ANCOVA F	P Value	ES
Parent Stress Index (PSI)[*]																											
Child Related	5	116.0	(18.5)	116.0	80	37	112.5	(22.4)	112.6	80	31	.63	.43	.02	115.6	(20.8)	115.3	80	36	110.4	(19.6)	110.7	77	35	1.19	.28	-.27
Other Related	6	129.8	(21.0)	130.7	68	37	130.3	(27.1)	129.4	65	31	.11	.74	.06	127.5	(27.9)	128.3	61	36	126.1	(24.9)	126.2	60	35	.44	.51	-.06
TOTAL	4	245.8	(34.4)	247.3	78	37	242.8	(45.2)	241.3	72	31	.64	.43	.17	243.0	(46.5)	2[illegible].4	72	36	236.4	(39.2)	236.0	69	35	.87	.35	-.16
Family Support Scale (FSS)[♦♦]																											
TOTAL	9														1.9	(7.9)	2.0		32	1.8	(.8)	1.8		32	1.24	.27	-.25
Family Adaptation[·] Cohesion Eval. (FACES)																											
Adaptation	19	21.8	(5.7)	21.8		36	21.6	(5.1)	21.6		31	.04	.85	-.04	21.1	(5.3)	21.1		35	22.1	(4.4)	22.2		32	.90	.35	.21
Cohesion	20	37.5	(6.7)	37.7		36	38.6	(5.2)	38.4		31	.32	.58	.10	37.5	(6.9)	37.9		35	38.7	(6.4)	38.3		32	.06	.81	.06
Child Improvement[**] (Locus of Control)																											
Professional	18	18.3	(4.2)	18.4		37	18.8	(4.12)	18.6		31	.03	.86	.05	19.4	(4.2)	19.5		36	18.3	(4.1)	18.1		32	1.70	.20	-.33
Divine Intervention	14	12.3	(3.6)	12.2		37	11.9	(3.6)	12.0		31	.03	.86	-.06	12.0	(3.2)	11.7		36	11.4	(3.7)	11.7		32	.01	.94	.00
Parent	5	22.3	(3.9)	22.3		37	24.0	(2.8)	24.0		31	3.87	.05	.44	23.3	(3.9)	23.3		36	23.3	(4.2)	23.3		32	.00	.96	.00
Child	12	21.4	(3.0)	21.1		37	21.0	(3.9)	21.3		31	.06	.81	.07	22.2	(2.6)	21.6		36	19.9	(5.7)	20.5		32	1.19	.28	-.42
Chance	12	12.1	(3.7)	11.4		37	9.5	(3.0)	10.2		31	2.59	.11	-.32	11.6	(3.7)	11.0		36	10.2	(4.2)	1'0.7		32	.13	.72	.00
CES-D Depression[*]	**6,12**	31.3	(9.4)	30.8		37	30.3	(8.4)	30.8		30	.00	.99	.00													
Parent as a Teacher[♦] Scale (PAAT)																											
Creativity	5	26.8	(1.8)	26.8		33	26.6	(2.0)	26.6		30	.15	.70	-.11	26.3	(2.5)	26.3		36	26.3	(1.9)	26.2		32	.03	.85	-.04
Frustration	4	27.0	(1.9)	27.0		33	27.2	(2.6)	27.3		30	.24	.63	.16	27.7	(2.7)	27.7		36	26.7	(1.5)	26.7		32	4.03	.05	-.37
Control	3	25.3	(2.8)	25.3		33	27.5	(2.5)	27.5		30	10.39	.00	.79	25.2	(2.4)	25.2		36	26.6	(2.2)	26.5		32	5.39	.02	.54
Play	4	29.2	(2.6)	29.1		33	29.8	(2.6)	29.9		30	1.37	.25	.31	29.0	(2.4)	29.0		36	28.9	(2.0)	29.0		32	.02	.90	.00
Teaching/Learning	5	28.9	(2.8)	28.9		33	29.6	(2.6)	29.6		30	1.13	.29	.25	29.1	(2.8)	29.2		36	29.2	(2.8)	29.1		32	.00	.96	-.04
TOTAL	4	137.2	(8.4)	137.1		33	140.8	(9.0)	141.0		30	3.61	.06	.46	137.3	(10.1)	137.3		36	137.6	(7.1)	137.6		32	.03	.87	.00

Effect Size (ES) is defined here as the difference between the groups (Classroom + PIE minus Classroom Only) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation of the Classroom-Only Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977, for a more general discussion of the concept of Effect Size). For the PSI and CES-D, the numerator for the ES is reversed, as lower scores are preferred.

[*] Statistical analysis for the PSI and CES-D were based on raw scores where low raw scores are most desirable.

[·] Scores for each subscale of the FACES are derived from linier scoring where higher scores are preferred.

[♦] Statistical analyses for the FRS and PAAT were based on raw scores where higher scores are preferred.

[♦♦] Analyses for the FSS is based on the sum of the preferred support scored divided by the number of scores of support available. Higher scores are preferred.

[•] Covariates: 1 = BDI adaptive; 2 = BDI motor; 3 = BDI Total; 4 = PSI Total; 5 = PSI Child; 6 = PSI other; 9 = FSS Total; 10 = FRS Total; 11 = FILE Total; 12 = PPVT Standard Score; 13 = Income; 14 = Motner Education; 15 = Hours of Daycare; 16 = Battelle Communication; 17 = Battelle Cognitive; 18 = Mothers Age; 19 = Adaptation; 20 = Cohesion; 21 = Siblings in home; 22 = FACES Perceived raw score; 23 = Ethnicity of child; 24 = FSS Total Support; 25 = Age of child at pretest; 26 = BDI Personal-Social; 27 = Ethnicity of Mother; 28 = Primary caretaker; 29 = Sex of child; 30 = Mother living with child; 31 = FSS sources of support; 32 = Father Education. Covariate numbers in standard type were used for both Reassessment #1 and #2, **bold** numbers were used for Reassessment #3 only, underlined numbers were used for Reassessment #4 only.

[**] On the Child Improvement Questionnaire, ESs are used only to indicate direction of result. See text for interpretation of findings. Statistical analyses are based on raw scores.

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Table 8.18 (continued)

Posttest Measures of Family Functioning for Des Moines Study

		Classroom Only				Classroom + PIE						
Variables	Covariates	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES
Reassessment #5												
Family Support Scale (FSS) TOTAL	24	1.7	(.69)	1.7	33	1.8	(.82)	1.9	30	.63	.43	.29
Child Improvement (Locus of Control)**												
Professional	18	18.4	(4.1)	18.6	35	18.7	(5.0)	18.6	30	.00	.97	.00
Divine Intervention	14	12.0	(3.0)	11.8	35	12.0	(3.3)	12.2	30	.27	.61	.13
Parent	5	23.5	(3.6)	23.5	35	24.3	(3.6)	24.3	30	1.16	.29	.22
Child	12	21.4	(3.1)	21.0	35	21.1	(4.2)	21.5	30	.27	.61	.14
Chance	12	11.1	(3.9)	10.4	35	10.0	(4.2)	10.7	30	.14	.71	.07
Comprehensive Evaluation of Family Functioning (CEFF)	4	76.7	(21.0)	76.9	35	77.1	(21.9)	76.9	30	.00	.99	.00
Parent Self-Awareness Scale												
Total	6	42.8	(6.5)	42.6	35	43.8	(6.9)	44.0	31	.96	.33	.22
REASSESSMENT #6												
Family Support Scale (FSS) Total	24	1.6	(.7)	1.6	34	2.0	(.8)	2.0	29	4.53	.04	.57
Parenting Stress Index (PSI) Short Form												
Parent Distress	6	25.1	(6.5)	25.3	34	26.4	(8.6)	26.3	29	.44	.51	-.15
Parent-Child Dysfunction	4	25.1	(7.5)	25.1	34	24.8	(6.9)	24.8	29	.05	.83	.04
Difficult Child	4	28.7	(8.1)	28.7	34	30.4	(8.9)	30.4	29	.81	.37	-.21
Dyadic Adjustment Scale (DAS)												
Dyadic Consensus	18	46.9	(9.2)	47.6	19	47.1	(7.9)	46.5	20	.16	.69	-.11
Dyadic Satisfaction	33	38.6	(5.3)	38.3	19	37.2	(7.7)	37.5	20	.25	.62	-.15
Affectional Expression	5	8.2	(2.5)	8.2	17	9.2	(2.1)	9.2	19	1.15	.29	.40
Dyadic Cohesion	1,35	15.8	(2.9)	15.5	19	14.1	(4.8)	14.4	20	.75	.39	-.38
Total Dyadic Adjustment	35,36	10.6	(1.4)	10.5	16	10.7	(1.5)	10.8	18	.73	.49	.21
Family Functioning Style Scale (FFSS)												
Family Identity	5,34	32.3	(5.7)	31.8	23	32.3	(6.5)	32.9	21	.64	.43	.19
Information Sharing	5,34	12.7	(2.0)	12.4	23	11.7	(2.8)	12.0	21	.66	.42	.20
Coping/Resource	5	34.6	(6.3)	34.5	24	33.5	(8.8)	33.6	21	.21	.65	-.14
REASSESSMENT #7												
Family Support Scale (FSS) Total	5	1.8	(.7)	1.8	32	2.0	(.7)	1.9	29	.07	.79	.14
Parent Stress Index--Short Form												
Parent Distress	6	25.1	(6.5)	25.3	34	26.4	(8.6)	26.3	29	0.44	.51	-.15
Parent-Child Dysfunction	4	25.1	(7.5)	25.1	34	24.8	(6.9)	24.8	29	0.05	.83	.04
Difficult Child	4	28.7	(8.1)	28.7	34	30.4	(8.9)	30.4	29	0.81	.37	-.21
Total Score	4	79.3	(19.0)	79.2	34	81.8	(21.1)	81.8	29	0.43	.52	-.14

Effect Size (ES) is defined here as the difference between the groups (Classroom + PIE minus Classroom Only) on the ANCOVA adjusted scores, divided by the unadjusted standard deviation of the Classroom-Only Intervention Group (see Glass, 1976; Tallmadge, 1977; and Cohen, 1977, for a more general discussion of the concept of Effect Size). For the PSI and CES-D, the numerator for the ES is reversed, as lower scores are preferred.

* Statistical analysis for the PSI and CES-D were based on raw scores where low raw scores are most desirable.

· Scores for each subscale of the FACES are derived from linier scoring where higher scores are preferred.

♦ Statistical analyses for the FRS and PAAT were based on raw scores where higher scores are preferred.

♦♦ Analyses for the FSS is based on the sum of the preferred support scored divided by the number of scores of support available. Higher scores are preferred.

* Covariates: 1 = BDI adaptive; 2 = BDI motor; 3 = BDI Total; 4 = PSI Total; 5 = PSI Child; 6 = PSI other; 9 = FSS Total; 10 = FRS Total; 11 = FILE Total; 12 = PPVT Standard Score; 13 = Income; 14 = Mother Education; 15 = Hours of Daycare; 16 = Battelle Communication; 17 = Battelle Cognitive; 18 = Mothers Age; 19 = Adaptation; 20 = Cohesion; 21 = Siblings in home; 22 = FACES Perceived raw score; 23 = Ethnicity of child; 24 = FSS Total Support; 25 = Age of child at pretest; 26 = BDI Personal-Social; 27 = Ethnicity of Mother; 28 = Primary caretaker; 29 = Sex of child; 30 = Mother living with child; 31 = FSS sources of support; 32 = Father Education.; 33 = Marital Status of mother; 34 = Relationship of mother to child; 35 = BDI expressive communication; 36 = Marital status of father

** On the Child Improvement Questionnaire, ESs are used only to indicate direction of result. See text for interpretation of findings. Statistical analyses are based on raw scores.

Classroom + PIE group reported less depression symptomatology. This finding could be associated with increased support perceived by these mothers.

A difference was found on one subscale of the Child Improvement Questionnaire (CIQ) which assesses locus of control perceptions. The CIQ was designed to measure parental beliefs concerning control over the improvement of children who are physically, emotionally, or developmentally impaired. A significant difference was found on the chance subscale. The subscale assesses parental beliefs that their child's improvement is largely a matter of fate or of factors beyond their control. Parents of children in the Classroom + PIE group were significantly less likely to believe their child's progress was due to fate. A belief that child improvement is not a chance occurrence may be associated with PIE. One goal of the PIE was to help the parents improve their intervention skills to increase the perceptions of themselves as a factor in their child's improvement. Therefore, group differences in the parent subscale of the CIQ was expected, but did not occur. This failure to find a difference decreases confidence in the parent empowerment aspects of the PIE as assessed by this measure.

In addition to the analyses reported in Table 8.18, the subscales of the PSI were analyzed. Some caution is suggested when making interpretations based on these results, as the PSI authors recommend against using the subscales for interpretive purposes. These subscales were analyzed here for exploratory purposes. On the subscales, a significant difference was found in parents' stress regarding their sense of competence, with those parents in the Classroom + PIE group viewing themselves as more competent (less stressed). No differences were found on the 12 other subscales of the PSI.

The results from measures of family functioning should be interpreted conservatively. The majority of comparisons (i.e., PSI, FACES) showed no differences between groups. The results of the FSS may be a treatment verification variable indicating that support was indeed provided as part of the PIE. It is also possible that in conducting as many analyses as were done here that findings of significance may occur, even when groups are comparable. The overall effects of adding this type of parent involvement group to an existing classroom-based early intervention program were quite small, if they exist at all. There is some evidence that mothers in the parent involvement group were less depressed, that they were less likely to attribute their child's condition to chance, and that they report more sources of support. These measures were ones that the Classroom + PIE intervention was hypothesized to potentially impact.

Reassessment #2. Statistically significant differences were found on the child and chance subscales of the Child Improvement Questionnaire. The finding on the chance subscale repeats that found at Reassessment #1. Classroom + PIE families were significantly less likely to believe their child's progress was due to fate. Classroom + PIE parents also attributed less of their child's progress to their child (i.e., within child attributions). Both of these differences could be attributed to the parent involvement component.

A significant difference was again found on the CES-D, but this time favoring the Classroom-Only group. This finding is the reverse of what occurred at Reassessment #1. A significant difference was found on the PAAT control subscale. This difference suggested that Classroom + PIE parents were exerting more control over their children in teaching situations. Different hypothetical viewpoints exist as to the advantages or disadvantages of parental directiveness (cf., Blasco, Hrncir, Blasco, 1990; Mahoney & Powell, 1988).

Overall, the results from family measures suggest that the only clear place that parent involvement may have affected families is on their attributions of progress in their child and on their directiveness in teaching situations. Other impacts seem negligible. Once again, it should be noted that some children and parents continued in intervention at this posttest, while others did not. This effect of this will be examined in later analyses.

Reassessment #3. Results from this posttest are presented in Table 8.18. Differences between the groups occurred on the parent scale of the CIQ, and on the control scale and total score of the PAAT. The results from the CIQ suggest that parents in the Classroom + PIE group view themselves as being an agent of change in their child's progress. This is a desired outcome of the parent involvement. The result from the PAAT suggest that the parents of children in the Classroom + PIE group exert more control over their child during teaching interactions (which replicates Reassessment #2 findings) and engage, overall, in more positive teaching interactions with their child. This result is also positive toward the parent involvement component. Although there appeared to be some small and limited benefits for this type of parent involvement program when added to a classroom-based program, the overall impact of the parent involvement component on a broad array of family functioning measures is negligible.

Reassessment #4. Table 8.18 presents results from this reassessment. Two differences between groups were found at this testing. Parents of children in the Classroom-Only group reported more frustration and exerted more control in learning situations on the PAAT. Reassessment #4 results, overall, showed no group differences. Even the positive attributions of child progress of the Classroom + PIE group faded by this posttest.

If you examine the results of the CIQ across reassessments, there is a clear trend toward statistically significant findings on subscales that favor the Classroom + PIE group in a manner consistent with expected intervention impacts. However, the specific subscales found to be statistically significant fluctuate. These results suggest a positive impact of intervention on parent attributions of child success in a direction over which the parents have greater control. The fluctuation in findings does suggest that these results need to be examined in future studies, perhaps using other instruments.

Reassessment #5. The reader will note some changes in family measures at Reassessment #5. These changes have been made to broaden the understanding of possible impacts on families, and the measures are described in Table 8.14. No statistically significant differences were found on the new scales nor on other measures. For the CEFF, all subscales were examined and statistically significant differences were not found. The failure to find any statistically significant difference on the CIQ may indicate that impacts that occurred to attributions as a result of intervention had dissipated.

Reassessment #6. Some changes have occurred in the measures for this reassessment. The Comprehensive Evaluation of Family Functioning (CEFF) has been replaced by the Parenting Stress Index--Short Form (PSI-SF). The PSI-SF addressed concerns about length that existed with the original Parenting Stress Index, and the PSI-SF was more sound psychometrically than the CEFF. The information obtained from the PSI-SF was consistent with information from past reassessments. Also at this reassessment, the Child Improvement (Locus of Control) was not administered because trends in these data had dissipated by reassessment #5. The PSAS was not administered at this reassessment because of concerns regarding the reliability of this measure.

At this reassessment, a statistically significant difference was found on the Family Support Scale, but no other statistically significant differences were found. This finding of a statistically significant difference on the FSS in favor of the Classroom + PIE group is inconsistent with the results from reassessments #4 and #5. This suggests the current finding may be a chance finding.

The Dyadic Adjustment Scale and Family Functioning Style Scale were also administered at this reassessment. These measures were added to gain information on aspects of family functioning not addressed by other instruments at past reassessments. No statistically significant differences were found on these measures.

Reassessment #7. Only the Parenting Stress Index--Short Form and Family Support Scale were administered at this reassessment. This was done to simplify longitudinal assessment procedures and because these measures have been extremely reliable over time. No statistically significant differences were found.

Parent/Child Interaction

It was possible that the alternative forms of intervention may have affected parent/child interactions in a way that was not detected by the family measures. Preliminary results from other EIRI studies provided evidence which suggested parent/child interactions may have been impacted by the parent involvement component. To determine if the alternative interventions had an effect on parent/child interactions, these interactions were assessed during the reassessment that occurred in 1990.

All children who were reassessed in 1990, and had parents who consented, were videotaped in a structured parent/child interaction situation. These children included subjects in Cohort #1 and #2. Therefore, some subjects were being tested for Reassessment #3 and others for Reassessment #4. The parent (typically mothers) and child were videotaped using a structured videotape protocol. Videotapes were scored using the Parental Behavior Rating Scale (Mahoney, Finger, & Powell, 1985) by observers trained and supervised by the scale developer, Gerald Mahoney.

The Parental Behavior Rating Scale assesses 12 variables that relate to parent/child interaction: expressiveness, enjoyment, warmth, sensitivity to child's interest, responsivity, achievement orientation, inventiveness, verbal praise, effectiveness, pace, acceptance, and directiveness. (Definitions of these variables can be obtained by writing EIRI or Dr. Mahoney.) Each factor is scored from 1 to 5, with 5 indicating greater amounts of the factor being measured. These 12 variables were divided into 3 major factors based on a maximum likelihood factor analysis with oblique rotation of these variables for 237 observations of parent-child interaction collected by the longitudinal studies. The three factors that were identified together accounted for 59.6% of the variance. Factor 1, Affective Relationship with

Child, included expressiveness toward child, warmth, enjoyment of interacting with child, acceptance of child's behaviors, and inventiveness in play. For Factor 2, Responsivity to Child, sensitivity to child's interests, responsivity, inventiveness in play, and effectiveness of parent to engage child in play interaction were summed and directiveness (frequency and intensity of directives) was subtracted. Factor 3, Performance Orientation, included achievement orientation, verbal praise, pace of parent's behaviors, and intensity and frequency of directives. The reliability coefficients of the three factors were .88, .83, and .61, respectively.

An analysis of covariance was conducted on scores from each of the 12 variables and from the 3 factors. Covariates were selected in the manner described earlier. No significant differences were found between groups on individual factors or major factors. The results for the three factors are presented in Table 8.19. These results indicate that aspects of parent/child interaction as assessed by this observational instrument were not impacted by the parent involvement component at this time. It is not known if parent/child interaction would have been impacted immediately following intervention.

Table 8.19

Measures of Parent/Child Interaction for Des Moines Parent Involvement Study

		Classroom-Only				Classroom + PIE						
Variable	Covariates'	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	F	p Value	ES
Chronological age at taping (months)	--	91.3	(13.0)		33	92.3	(12.0)		30	.22	.64	.08
Responsivity	1	14.3	(2.7)	14.3	33	14.9	(3.0)	14.9	30	.65	.42	.22
Performance Orientation	1	8.2	(2.7)	8.1	33	8.8	(2.8)	8.8	30	.97		.26
Affective Relationship	1	12.8	(3.1)	12.8	33	13.8	(2.8)	13.8	30	1.97	..	.32

1 = CA at taping

$$ES = \frac{Adj.\bar{x}\ (Classroom + PIE) - Adj.x\ (Classroom\text{-}Only)}{SD\ (Classroom\text{-}Only)}$$

Classroom Follow-Up

The importance of assessing the perceived effects of interventions on others in the child's environment has been discussed by interventionists (Fleischer, Belgredan, Bagnato, & Ogonsky, 1990). In fact, some of the most interesting long-term results of early intervention programs for children who are disadvantaged has been in areas other than those specifically targeted by the program (e.g., prevention of juvenile delinquency) (Zigler, Taussig, & Black, 1992). In this study, it is possible that the effects of this type of parent involvement component may not become apparent until the child is in elementary school. Teacher information will be reported from the analysis of those data collected from teachers following Reassessment #4, #5, and #6. Initially, these education outcome data were collected in the Fall following each reassessment (#4 and #5), and asked teachers to provide information based on the performance of the child during the past academic year. This system was acceptable to the Des Moines Public School District, but lead to some confusion among teachers who had the child in their classroom for multiple years. This process was changed for Reassessment #6, after consultation with the school district, to one where school data are collected in the spring of the academic year for that academic year (e.g., 92/93 academic year data collected in April 1993). This system has been used to collect Reassessment #6-#8 data. Reassessment #7 data are currently being analyzed. Reassessment #8 data are in the process of being obtained.

To obtain classroom information, teachers are asked to complete a questionnaire on the child and the child's classroom placement. Teachers are requested to complete protocols on their own time and are paid for their participation. Information is requested on the teacher's perception of the child's parents, as well as some teacher specific and general classroom information. Teachers also complete other protocols (i.e., SPECS, SSRS) at this time, dependent on reassessment.

Reassessment #4. Each child's current teacher was contacted for reassessment #4 in the fall of the academic year following the one during which the child had been in their classroom. The teacher contacted was the one in whose classroom the child received the majority of services (i.e., self-contained, resource, typical, etc.). Teachers completed information on child educational placement, teacher perceptions of the child's parents, and teachers' perception of the child using the Developmental SPECS.

The teachers of 70 subjects were contacted based on parental permission to obtain school-related information. Protocols were returned on 60 subjects, 46 were Cohort #1 subjects and 14 were Cohort #2 subjects.

Information obtained from these teachers is presented in Table 8.20 and 8.21. Table 8.20 presents descriptive information on children's placement. The majority of children are in self-contained classrooms and in mixed grade placements. Almost all children who receive special education services were involved in inclusion activities (mainstreaming).

Table 8.20

Descriptive Information on School Placement at Reassessment #4 by Numbers of Subjects for Des Moines Parent Involvement Study

	Classroom-Only (n = 29)	Classroom + PIE (n = 31)
GRADE		
Preschool/Kindergarten^	6	4
1st	4	6
2nd	7	6
3rd	2	2
Mixed Grade*	10	13
MAINSTREAMED#		
Not Mainstreamed	2	2
Academic Mainstreaming+	3	1
Nonacademic Mainstreaming	13	10
All day Mainstreaming	10	12
PRIMARY PLACEMENT		
Typical Class	1	6
Typical Class + Resource	6	6
Self-Contained Class	22	19

* All mixed grade were in self-contained placements

+ Includes academic and nonacademic mainstream placements, as long as subject is mainstreamed for some academic subjects.

^ Child may remain in a preschool placement through age six.

# Only includes children who are not in a typical class placement.

Table 8.21

Results of Longitudinal Educational Outcomes at Reassessment 4

Variables	Covariates'	Classroom Only			Classroom + PIE			p Value	ES
		Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n		
• Child Variables'									
Percent with special education classification		93.1		29	83.9		31	.27	.39
• Teacher SPECS									
Communication	3	6.4	(1.6)	28	7.2	(1.5)	31	.05	.50
Sensory Motor	3	16.0	(2.8)	28	17.0	(2.8)	31	.15	.36
Physical	3	12.3	(1.8)	28	13.1	(2.0)	30	.14	.44
Self Regulation	3	13.8	(3.2)	28	15.8	(3.0)	31	.02	.63
Cognition	3	5.8	(2.2)	28	7.1	(1.7)	31	.009	.59
Self-Social	3	13.1	(3.3)	28	15.4	(3.0)	31	.003	.70
• Ratings of Parents									
Attendance	1,2	2.4	(.7)	26	2.7	(.7)	31	.31	.43
Knowledge	1,2	2.1	(.7)	26	2.3	(.7)	31	.28	.29
Cooperation	1,2	2.2	(.8)	26	2.5	(.7)	31	.19	.38

' Covariates: 1 = Income, 2 = Mother's Education, 3 = BDI Adaptive Domain

$$\text{ES} = \frac{\text{Adj. }\bar{x}\text{ (Classroom + PIE)} - \text{Adj. }\bar{x}\text{ (Classroom only)}}{\text{SD (Classroom Only)}}$$

For measures where low scores are indicative of higher functioning, the sign is reversed so that a positive ES always means that the classroom + PIE group did better and a negative ES always means that the classroom group did better. Raw scores were used in all analyses except where noted. For a more complete discussion of the concept of Effect Size, see Cohen, 1977; Glass, 1976; and Tallmadge, 1977.

' Statistical analyses for these variables were based on a t-test where subjects possessing the trait were scored "1" and those not possessing the trait "0." ESs for these variables are based on a probit transformation.

Results of information obtained from the teachers is presented in Table 8.21. All data were analyzed using analysis of covariance, except child placement variables, which were analyzed by t-tests. No difference was found in the number of children in each group who were special education classified. Statistically significant differences were found on four of the six SPECS domains in favor of the Classroom + PIE group.

Of 10 educational outcomes, 5 were statistically significant and the average effect size was .47. These results suggest that the parent involvement program may have impacted child development in a way not measured by the other child outcome variables and/or may have impacted aspects of the parent/professional relationship.

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However, these results must be interpreted cautiously. Other similar EIFI studies have not found similar education outcomes (Utah Parent Involvement in this report; Boyce, White, & Kerr, 1993). If these findings are confirmed longitudinally, then examination of those aspects of intervention that contributed to these results must be explored in greater detail.

Reassessment #5. The same procedures used to contact teachers at Reassessment #4 were used at this reassessment. The teachers of all subjects were contacted based on parental permission to obtain school-related information. Protocols were returned on 45 subjects. Information obtained from teachers are presented in Tables 8.22 and 8.23. Three instrumentation changes occurred from Reassessment #4. The SPECS was replaced by the Social Skills Rating Scale. This was done to accommodate the increasing age and grade placements of the subjects. Information on mainstreaming was not requested because of concerns regarding the interpretation of mainstreaming by subjects' teachers. The scale collecting information from the teachers regarding parents was also changed to accommodate the increasing age of subjects.

Table 8.22 shows descriptive information on the subject's classroom placement. Comparative results of information obtained from the teachers is presented in Table 8.23. No statistically significant differences were found on child class placement variables. A statistically significant difference was found on the Skills Total of the SSRS and on the Parent Knowledge Scale of the teacher rating of parents. The statistically significant result of the SSRS suggests the children in the classroom-Only group were demonstrating better social skills in their classroom placements. The result regarding parent knowledge suggests that parents in the classroom + PIE group were demonstrating better knowledge in interactions with teachers.

Table 8.22

Descriptive Information on School Placement at Reassessment #5 by Numbers of Subjects for Des Moines Parent Involvement Study

Grade	Classroom-Only (n = 21)	Classroom + PIE (n = 23)
Kindergarten	0	0
1st	1	2
2nd	3	2
3rd	5	7
4th	7	4
5th	3	2
6th	0	1
Primary Placement		
Typical Class	1	2
Typical Class + Resource	6	7
Self-Contained Class	12	9

* Include children who only get therapy

Table 8.23

Results of Longitudinal Educational Outcomes at Reassessment #5

		Classroom Only			Classroom + PIE			p	
Variables	Covariates'	Adj. $\bar{x}$	(SD)	n	Adj. $\bar{x}$	(SD)	n	Value	ES'
• Child Variables'									
% in typical classroom placement w/o related services		88.9		18	100.0		18		
% with special ed classification		11.1		18	0.0		18		
• Teacher Social Skills Rating Scale (Standard Scores)									
Skills Total	3,4	91.8	(13.1)	18	83.9	(11.2)	18	.06	
Problem Behaviors	5	109.6	(13.3)	18	112.0	(14.9)	18	.61	
Academic Competence		87.0	(12.1)	18	84.3	(12.7)	17	.63	
• Ratings of Parents									
Skill/Activity/Support	1,2	88.4	(22.0)	32	89.8	(16.7)	28	.79	
Knowledge		104.3	(14.8)	32	110.8	(12.6)	28	.08	

' Covariates: 1 = Income, 2 = Mother's Education, 3 = BDI Adaptive Domain, 4 = PPVT Standard Score, 5 = FRS Total, 6 = BDI [illegible]

$$ES = \frac{\text{Adj. } \bar{x} \text{ (Classroom + PIE)} - \text{Adj. } \bar{x} \text{ (Classroom only)}}{\text{SD (Classroom Only)}}$$

For measures where low scores are indicative of higher functioning, the sign is reversed so that a positive ES always means that the classroom + PIE group did better and a negative ES always means that the classroom group did better. Raw scores were used in all analyses except where noted. For a more complete discussion of the concept of Effect Size, see Cohen, 1977; Glass, 1976; and Tallmadge, 1977.

' Statistical analyses for these variables were based on a t-test where subjects possessing the trait were scored "1" and those not possessing the trait "0." ESs for these variables are based on a probit transformation.

These results are different from those obtained at Reassessment #4, even when the changes in the instrumentation are taken into account. One problem relates to the poor return rate obtained on the teacher information. There were 15 fewer subjects available for the analyses completed at this reassessment. This decrease in return rates makes comparisons across reassessments difficult. Conclusions regarding possible impacts in this area await further reassessments and analyses.

Reassessment #6. As noted earlier, the procedures used to contact teachers changed at this reassessment. This change created some confusion. The teachers of children who had a child in their classroom for multiple years (which includes many of the special education eligible children), had already completed one set of measures during the academic year and were not willing to complete a second set. Although our request was for information on a different year, the teachers had difficulty distinguishing differences in our request for information, and considered the information redundant. This impacted on our return rate. The sample for this reassessment consists of responses from 36 teachers.

The information collected was the same as that collected at Reassessment #5. Descriptive data on classroom placement are presented in Table 8.24 and other data are presented in Table 8.25. The results reported in Table 8.25 are very similar to those reported for Reassessment #5 (Table 8.23). At both reassessments, a statistically significant difference was found on the teacher ratings of parent knowledge, favoring the Classroom + PIE group, and on the Skills Total of the Social Skills Rating Scale, favoring the Classroom-Only group.

These results need further investigation before conclusions can be drawn. The small sample size at Reassessments #5 and #6 suggests the need to determine if these subsamples are or are not representative of the larger sample. Although covariance procedures help to adjust for any differences at pretest, we may still have substantially different groups in relation to one or many variables. This will be examined before conducting further analyses.

Table 8.24

Descriptive Information on School Placement at Reassessment #6

Grade	Classroom Only	Classroom + PIE
First	1	2
Second	3	2
Third	5	7
Fourth	7	4
Fifth	3	2
Sixth	0	1
Primary Placement		
Typical Class*	1	2
Typical Class + Resource	6	7
Self-Contained Class	12	9

* Includes children who only receive therapy

Table 8.25

Results of Longitudinal Educational Outcomes at Reassessment #6

		Classroom Only			Classroom + PIE			p	
Variables	Covariates*	Adj. $\bar{x}$	(SD)	n	Adj. $\bar{x}$	(SD)	n	Value	ES
• Child Variables•									
% with special education classification		88.9		18	100.0		18	.30	.33
• Teacher Social Skills Rating Scale (Standard Scores)									
Skills Total	3,4	91.8	913.1)	18	83.9	(11.2)	18	.06	-.60
Problem Behaviors	5	109.6	(13.3)	18	112.0	(14.9)	18	.61	.18
Academic Competence	5,6	87.0	(12.1)	18	84.3	(12.7)	17	.63	-.22
• Ratings of Parents									
Skill/Activity/Support	1,2	88.4	(22.00	32	89.8	(16.7)	23	.79	.06
Knowledge	1,2	104.3	(14.80	32	110.8	(12.6)	28	.08	.44

* Covariates: 1= Income, 2 = Mother's Education, 3 = BDI Adaptive, 4 = PPVT Standard Score, 5 = FRS Total, 6 = BDI Motor

$$ES = \frac{\text{Adj. } \bar{x} \text{ (Classroom + PIE) - Adj. } \bar{x} \text{ (Classroom only)}}{\text{SD (Classroom Only)}}$$

For measures where low scores are indicative of higher functioning, the sign is reversed so that a positive ES always means that the classroom + PIE group did better and a negative ES always means that the classroom group did better. Raw scores were used in all analyses except where noted. For a more complete discussion of the concept of Effect Size, see Cohen, 1977; Glass, 1976; and Tallmadge, 1977.

• Statistical analyses for these variables were based on a t-test where subjects possessing the trait were scored "1" and those not possessing the trait "0." ESs for these variables are based on a probit transformation.

Analysis of One Year vs. Two Years of Intervention

In the analyses presented earlier for Reassessments #2 through #6, the existence of a possible confound was mentioned. This possible confound is that the Classroom + PIE group consists of subjects who received two years of parent involvement intervention and subjects who received one year of parent involvement intervention. The analyses reported in this section was conducted to determine the effects of these different durations of parent involvement on the data collected.

A Oneway analysis of covariance was conducted on all child and family outcome measures, reported earlier, for Reassessments #2 through #6. The groups compared were the Classroom-Only group, the group who received one year of the parent involvement intervention (Classroom + PIE), and the group who received two years of the parent involvement intervention (Classroom + PIE I + PIE II). Covariates used in the analyses were the same as those reported for each measure on the earlier analyses (Tables 8.16 - 8.18).

The majority of results from these analyses are presented in Table 8.26. This table does not present data on all measures in order to simplify the table. Any measure where a significant difference between groups was found is presented in the table.

Table 8.26

Oneway Analysis of Covariance Results on Child and Family Outcome Measures for Classroom-Only Subjects and Subjects Receiving One (Classroom + PIE I) or Two Years (Classroom + PIE I + PIE II) of Parent Involvement Activities for Des Moines Parent Involvement Study

	Classroom-Only			Classroom + PIE I			Classroom + PIE I + PIE II				
Variables'	Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n	ANCOVA F	p Value
Reassessment #2											
• **Battelle Developmental Inventory**											
Personal/Social	130.9	(25.4)	37	128.3	(34.1)	14	132.8	(31.0)	19	.24	.79
Adaptive Behavior	85.6	(18.0)	37	87.2	(20.3)	14	87.8	(18.0)	19	.30	.74
Motor	116.3	(24.8)	37	113.5	(34.6)	14	116.7	(30.9)	19	.36	.70
Communication	67.6	(18.9)	37	65.8	(24.8)	14	69.2	(21.7)	19	.34	.71
Cognitive	65.1	(23.0)	37	62.9	(24.9)	14	69.6	(24.9)	19	1.31	.28
TOTAL	463.5	(97.7)	37	461.0	(129.2)	14	474.7	(115.9)	19	.38	.69
• **Parenting Stress Index (Total)**♦	249.3	(35.5)	35	246.0	(21.9)	13	254.1	(48.3)	19	.38	.68
• **Family Adaptation and Cohesion**♣ **Evaluation Scales**											
Cohesion	37.0	(7.2)	34	33.7	(6.2)	14	39.1	(7.0)	18	4.99	.01
Adaptation	21.2	(5.4)	34	21.0	(4.8)	14	19.7	(5.5)	18	.57	.57
• **CES-D**♦	29.4	(6.7)	36	32.1	(10.7)	14	34.7	(13.0)	19	2.58	.08
• **Child Improvement Questionnaire**											
Professional	19.9	(4.5)	36	17.2	(3.4)	13	20.7	(3.5)	19	3.14	.05
Divine Intervention	11.2	(3.4)	36	12.5	(2.9)	13	11.2	(4.0)	19	.80	.46
Parent	23.8	(2.8)	36	23.4	(3.6)	13	24.3	(2.9)	19	.38	.69
Child	21.4	(4.0)	36	20.5	(3.3)	13	19.3	(3.9)	19	2.27	.11
Chance	12.7	(4.6)	36	11.3	(3.3)	13	8.6	(2.8)	13	6.54	.00
TOTAL	88.8	(14.3)	36	85.4	(9.6)	13	83.9	(9.2)	19	.96	.39
• **Parent as a Teacher (PAAT)**											
Creativity	26.7	(1.6)	34	26.4	(1.3)	13	27.5	(3.3)	19	1.27	.29
Frustration	27.1	(2.1)	34	26.0	(1.6)	13	27.1	(3.7)	19	1.08	.35
Control	25.7	(2.7)	34	26.7	(2.0)	13	27.2	(3.0)	19	1.97	.15
Play	28.8	(2.5)	34	28.3	(1.9)	13	30.0	(3.3)	19	2.09	.13
Teaching/Learning	28.7	(2.7)	34	29.4	(2.2)	13	30.0	(3.4)	19	1.49	.23
TOTAL	136.9	(8.3)	34	136.1	(5.1)	13	142.3	(14.1)	19	2.64	.08

(continued)

♣ Scores for the FACES are derived from linear scoring.

♦ Lower scores are preferred

' Adjusted means are presented. Covariates used were the same as those reported in Tables 8.16 - 8.18.

Table 8.26 (continued)

	Classroom-Only			Classroom + PIE I			Classroom + PIE I + PIE II				
Variables'	Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n	ANCOVA F	p Value
Reassessment #3											
• **Battelle Developmental Inventory**											
Personal/Social	144.5	(17.2)	37	143.2	(29.8)	13	147.3	(26.6)	18	.29	.75
Adaptive Behavior	94.5	(15.5)	37	93.8	(20.6)	13	98.9	(22.0)	18	1.01	.37
Motor	124.8	(23.1)	37	124.4	(34.2)	13	126.5	(32.4)	18	.14	.87
Communication	77.5	(20.9)	37	74.4	(29.3)	13	79.4	(21.8)	18	.53	.59
Cognitive	76.7	(22.8)	37	68.5	(27.1)	13	77.9	(24.7)	18	2.03	.14
TOTAL	517.6	(89.0)	37	508.0	(135.1)	13	526.7	(117.7)	18	.42	.66
• **Parenting Stress Index (Total)**♦	247.4	(34.4)	37	237.9	(32.8)	13	244.0	(52.7)	18	.46	.63
• **Family Adaptation and Cohesion**♣ **Evaluation Scales**											
Cohesion	37.7	(6.7)	36	36.8	(6.0)	13	39.9	(4.6)	18	2.05	.14
Adaptation	21.8	(5.7)	36	22.8	(5.5)	13	20.7	(4.6)	18	.73	.48
• **CES-D**♦	30.6	(9.4)	37	31.4	(9.4)	12	29.9	(8.0)	18	.13	.88
• **Child Improvement Questionnaire**											
Professional	18.3	(4.2)	37	17.0	(4.8)	13	20.1	(3.3)	18	2.21	.12
Divine Intervention	12.5	(3.6)	37	11.6	(4.2)	13	12.0	(3.1)	18	.33	.72
Parent	22.4	(3.9)	37	23.2	(3.2)	13	24.4	(2.2)	18	2.28	.11
Child	20.8	(3.0)	37	21.7	(4.5)	13	21.1	(3.4)	18	.34	.71
Chance	11.5	(4.1)	37	10.9	(3.4)	13	9.1	(2.4)	18	3.85	.03
TOTAL	85.5	(12.8)	37	84.6	(13.1)	13	86.1	(7.1)	18	.08	.93
• **Parent as a Teacher (PAAT)**											
Creativity	26.9	(1.8)	33	26.6	(1.9)	12	26.6	(2.1)	18	.26	.77
Frustration	27.0	(1.9)	33	26.2	(1.9)	12	28.0	(2.9)	18	3.16	.05
Control	25.5	(2.8)	33	27.6	(2.4)	12	27.2	(2.6)	18	3.85	.03
Play	29.1	(2.6)	33	29.0	(2.6)	12	30.5	(2.6)	18	2.41	.10
Teaching/Learning	29.2	(2.8)	33	28.5	(2.4)	12	30.3	(2.6)	18	2.01	.14
TOTAL	137.2	(8.4)	33	139.0	(7.6)	12	142.1	(9.8)	18	1.80	.17

(continued)

♣ Scores for the FACES are derived from linear scoring.
♦ Lower scores are preferred
Adjusted means are presented. Covariates used were the same as those reported in Tables 8.16 - 8.18.

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Table 8.26 (continued)

Variables	Classroom-Only			Classroom + PIE I			Classroom + PIE I + PIE II			ANCOVA F	p Value
	Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n		
Reassessment #4											
• **Woodcock-Johnson**											
Broad Knowledge	45.0	(13.0)	37	43.6	(17.3)	15	47.6	(16.6)	19	.69	.50
Skills	45.9	(24.1)	37	41.5	(23.4)	15	48.3	(25.6)	19	.74	.48
• **Scales of Independent Behavior**											
Motor	457.0	(22.6)	36	454.8	(40.6)	15	462.6	(41.1)	19	.75	.48
Social & Communication	463.5	(14.8)	37	462.7	(22.2)	15	467.5	(19.7)	19	.89	.42
Personal Living	467.5	(17.6)	35	470.5	(25.4)	15	469.2	(25.2)	19	.27	.76
Community Living	441.2	(24.0)	36	454.1	(23.80	15	444.5	(26.7)	19	.88	.42
TOTAL	457.3	(17.5)	35	460.1	(26.8)	15	460.6	(26.7)	19	.46	.64
• **Parenting Stress Index (Total)**♦	241.5	(46.0)	36	232.2	(31.6)	14	241.2	(44.4)	18	.50	.61
• **Family Adaptation and Cohesion**♣ **Evaluation Scales**											
Adaptation	21.1	(5.2)	36	22.1	(5.1)	14	22.2	(4.0)	18	.46	.63
Cohesion	37.8	(6.8)	36	37.0	(5.9)	14	39.8	(6.7)	18	1.18	.32
• **Child Improvement Questionnaire**											
Professional	19.3	(4.2)	36	16.9	(4.3)	14	19.3	(3.5)	18	1.88	.16
Divine Intervention	11.7	(3.2)	36	12.3	(2.7)	14	11.0	(4.1)	18	.57	.57
Parent	23.1	(3.9)	36	21.7	(5.0)	14	24.6	(3.0)	18	2.21	.12
Child	21.4	(2.6)	36	19.1	(7.0)	14	21.3	(4.5)	18	1.74	.18
Chance	11.0	(3.7)	36	11.8	(4.8)	14	9.5	(2.9)	18	2.15	.13
TOTAL	86.1	(9.7)	36	82.0	(9.8)	14	86.1	(9.7)	18	1.28	.29
• **Parent as a Teacher (PAAT)**											
Creativity	26.4	(2.5)	36	26.5	(1.3)	14	26.0	(2.3)	18	.34	.71
Frustration	27.7	(2.7)	36	26.1	(.8)	14	27.1	(1.7)	18	2.82	.07
Control	25.7	(2.4)	36	26.9	(1.9)	14	25.8	(2.5)	18	1.83	.17
Play	29.3	(2.4)	36	28.6	(1.8)	14	28.9	(2.1)	18	.66	.52
Teaching/Learning	29.6	(3.6)	36	28.9	(2.9)	14	28.9	(2.8)	18	.45	.64
TOTAL	138.8	(10.1)	36	137.1	(5.5)	14	136.4	(8.2)	18	.48	.62
• **SPECS**											
Communication	6.4	(1.6)	28	7.1	(1.4)	14	7.3	(1.7)	17	2.00	.01
Sensorimotor	16.0	(2.8)	28	16.5	(2.6)	14	17.4	(2.9)	17	1.53	.23
Physical	12.3	(1.8)	28	12.6	(2.2)	14	13.4	(1.9)	17	1.78	.18
Self-Regulation	13.8	(3.2)	28	15.8	(3.3)	14	15.7	(2.8)	17	2.91	.06
Cognition	5.7	(2.2)	28	6.4	(1.6)	14	7.7	(1.7)	17	5.89	.01
Self/Social	13.0	(3.3)	28	14.9	(3.4)	14	15.8	(2.7)	17	5.37	.01

♣ Scores for the FACES are derived from linear scoring.

♦ Lower scores are preferred

Adjusted means are presented. Covariates used were the same as those reported in Tables 8.16 - 8.18.

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Table 8.26 (continued)

Variables	Classroom-Only Adj.$\bar{x}$	Classroom-Only (SD)	Classroom-Only n	Classroom + PIE I Adj.$\bar{x}$	Classroom + PIE I (SD)	Classroom + PIE I n	Classroom + PIE I + PIE II Adj.$\bar{x}$	Classroom + PIE I + PIE II (SD)	Classroom + PIE I + PIE II n	ANCOVA F	p Value
Reassessment #5											
• **Woodcock-Johnson**											
Broad Knowledge	467.5	(19.3)	38	466.9	(26.3)	15	466.9	(24.6)	18	.01	.99
Skills	432.6	(40.6)	38	432.4	(42.0)	15	435.1	(53.0)	18	.04	.96
• **Scales of Independent Behavior**											
Motor	462.3	(22.3)	38	457.0	(38.1)	15	461.0	(38.1)	18	.42	.66
Social & Communication	467.7	(13.6)	38	465.3	(18.2)	15	471.1	(17.0)	18	1.01	.37
Personal Living	474.4	(15.0)	38	469.0	(25.5)	15	474.4	(24.8)	18	.95	.39
Community Living	452.6	(25.8)	38	452.9	(23.8)	15	452.5	(24.1)	18	.00	1.00
TOTAL	464.0	(16.8)	38	461.9	(25.4)	15	464.5	(23.8)	18	.16	.86
• **Comprehensive Evaluation of Family Functioning**	76.9	(21.0)	35	73.8	(26.4)	13	79.3	(17.9)	17	.32	.73
• **Child Improvement Questionnaire**											
Professional	18.4	(4.1)	35	16.7	(3.8)	13	20.3	(5.3)	17	2.51	.09
Divine Intervention	12.0	(3.0)	32	12.1	(2.4)	13	12.2	(4.0)	17	.04	.96
Parent	23.6	(2.5)	35	22.3	(3.5)	13	25.8	(2.9)	17	5.40	.01
Child	20.8	(3.1)	32	21.1	(3.1)	13	21.5	(4.9)	17	.26	.77
Chance	10.2	(4.0)	33	10.4	(2.5)	13	10.6	(5.2)	17	.08	.92
• **Harter Scales**											
Cognitive Competence	20.6	(2.3)	34	20.7	(1.9)	14	21.3	(2.3)	14	.54	.59
Peer Acceptance	16.8	(4.2)	37	20.1	(2.8)	14	16.3	(6.1)	14	3.37	.04
Physical Competence	19.1	(3.4)	37	20.4	(2.7)	14	20.7	(3.1)	14	1.93	.16
Maternal Acceptance	16.5	(4.1)	36	18.1	(3.7)	14	17.2	(4.4)	14	.81	.45
• **Social Skills Rating Scale (Parent)**											
Social Skills	88.5	(15.3)	36	85.6	(15.0)	14	92.2	(17.0)	17	.87	.42
Problem Behaviors	116.5	(62.8)	38	92.7	(19.2)	14	110.2	(16.4)	17	1.25	.29

† Scores for the FACES are derived from linear scoring.

• Lower scores are preferred

Adjusted means are presented. Covariates used were the same as those reported in Tables 8.16 - 8.18.

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Table 8.26 (continued)

Variables	Classroom-Only Adj.$\bar{x}$	Classroom-Only (SD)	Classroom-Only n	Classroom + PIE I Adj.$\bar{x}$	Classroom + PIE I (SD)	Classroom + PIE I n	Classroom + PIE I + PIE II Adj.$\bar{x}$	Classroom + PIE I + PIE II (SD)	Classroom + PIE I + PIE II n	ANCOVA F	p Value
Reassessment #6											
• **Woodcock-Johnson**											
Broad Knowledge	472.7	(20.3)	37	468.9	(28.1)	15	472.6	(28.1)	17	0.24	.79
Skills	443.6	(39.0)	37	439.7	(50.6)	15	446.2	(60.3)	17	0.11	.89
• Scales of Independent Behavior											
Motor	468.6	(18.4)	37	461.2	(36.9)	15	463.1	(41.3)	16	0.80	.45
Social & Communication	472.3	(13.8)	37	466.4	(18.2)	15	472.5	(20.5)	16	1.29	.28
Personal Living	478.2	(13.8)	37	473.3	(24.1)	15	475.2	(28.0)	16	0.61	.55
Community Living	458.0	(23.4)	37	455.4	(26.9)	15	457.2	(27.2)	16	0.10	.91
TOTAL	468.9	(15.3)	37	464.9	(25.2)	15	467.0	(27.0)	16	0.42	.66
• Harter Scales											
Cognitive Competence	20.8	(2.7)	30	21.0	(2.5)	11	20.4	(2.1)	10	0.20	.82
Peer Acceptance	17.9	(3.8)	30	17.4	(4.0)	11	15.6	(5.5)	10	1.08	.35
Physical Competence	20.3	(3.5)	30	19.8	(1.9)	11	21.7	(2.6)	10	1.20	.31
Maternal Acceptance	16.1	(4.2)	30	16.6	(3.9)	11	17.9	(4.4)	10	0.70	.50
• Social Skills Rating Scale (Parents)											
Social Skills	89.5	(21.5)	35	86.2	(17.4)	13	94.1	(16.6)	15	0.57	.57
Problem Behaviors	105.8	(14.4)	35	109.0	(14.9)	12	111.3	(11.0)	16	1.23	.30

Adjusted means are presented. Covariates used were the same as those reported in Tables 8.16 - [illegible].

Table 8.26 (continued)

Variables	Classroom-Only			Classroom + PIE I			Classroom + PIE I + PIE II			ANCOVA F	p Value
	Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n	Adj.$\bar{x}$	(SD)	n		
Reassessment #7											
• Woodcock-Johnson											
Broad Knowledge	478.4	(19.9)	37	472.5	(27.9)	15	481.0	(28.1)	18	0.84	.43
Skills	451.7	(39.6)	37	446.3	(44.0)	15	461.7	(54.5)	18	0.80	.45
• Scales of Independent Behavior											
Motor	473.4	(19.6)	37	463.7	(38.9)	15	470.1	(39.5)	18	1.07	.35
Social & Communication	473.5	(17.3)	37	472.8	(24.4)	15	477.8	(21.3)	18	0.50	.61
Personal Living	481.5	(16.0)	37	480.7	(28.3)	15	480.2	(26.8)	18	0.04	.96
Community Living	461.8	(23.8)	37	463.3	(31.4)	15	466.1	(26.0)	18	0.28	.76
TOTAL	472.6	(17.0)	37	471.2	(29.5)	15	470.4	(27.0)	18	0.11	.90
• Harter Scales											
Cognitive Competence	20.8	(2.8)	34	20.5	(3.0)	12	21.6	(2.3)	12	0.53	.59
Peer Acceptance	17.9	(4.4)	34	16.9	(5.6)	12	18.9	(4.2)	12	0.54	.59
Physical Competence	21.0	(3.1)	34	19.9	(2.7)	12	21.0	(3.1)	12	0.67	.52
Maternal Acceptance	16.3	(4.0)	34	17.2	(5.3)	12	15.2	(5.6)	12	0.58	.56
• Social Skills Rating Scale (Parents)											
Social Skills	91.8	(17.3)	36	87.7	(20.2)	14	96.6	(20.2)	17	1.00	.37
Problem Behaviors	105.7	(16.5)	34	100.5	(10.1)	13	111.5	(13.9)	18	2.67	.08

No statistically significant differences were found on the majority of the measures. The measures on which a significant difference ($p \leq .10$) was found are presented with further analyses in Table 8.27. Overall, the results from Table 8.26 suggest that the different durations of participation in the parent involvement component did not impact on outcome measures.

Table 8.27

Direction of Significant Results from Oneway Analysis of Covariance (Table 8.20) for Des Moines Parent Involvement Study

	Classroom-Only vs. Classroom + PIE I		Classroom-Only vs. Classroom + PIE I + PIE II		Classroom + PIE I vs. Classroom + PIE I + PIE II	
Variable	ES*	p♦ Value	ES*	p♦ Value	ES*	p♦ Value
Reassessment #2						
• CES-D	.34	.29	.60	.04	.22	.55
• Child Improvement Questionnaire						
Professional	-.66	.05	.18	.54	1.02	.01
Chance	-.33	.32	-1.03	.00	-.90	.02
• FACES Cohesion	-.53	.10	.29	.32	.87	.02
• PAAT Total	-.11	.74	.52	.07	.59	.11
Reassessment #3						
• Child Improvement Questionnaire						
Chance	.27	.42	-.68	.02	-.66	.08
• PAAT						
Frustration	-.43	.21	.49	.10	.76	.05
Play	-.04	.90	.55	.07	.06	.13
Control	-.73	.02	-.25	.39	.76	.04
Reassessment #4						
• PAAT						
Frustration	-.73	.02	-.25	.39	.76	.04
• SPEC						
Communication	.46	.17	.55	.08	.13	.73
Self-Regulation	.62	.06	.62	.05	.03	.93
Cognition	.35	.29	.99	.00	.79	.04
Self/Social	.57	.09	.91	.01	.30	.42
Reassessment #5						
• Harter Scales	.86	.01	-.11	.74	.85	.03
• Child Improvement Questionnaire						
Professional	-.42	.20	.42	.15	.77	.04
Parent	-.47	.15	.84	.01	1.11	.01
Reassessment #6						
• Scales of Independent Behavior Social/Communication	-.50	.03	.04	.88	.14	.54

* ES was computed by subtracting the Adj. $\bar{x}$ of the second listed group from the mean of the first listed group and dividing this by the pooled for the two groups. For example:

$$\frac{\text{Adj. } \bar{x} \text{ (Classroom + PIE + PIE II)) - Adj. } \bar{x} \text{ (Classroom + PIE I)}}{\text{SD (Pooled)}}$$

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Table 8.27 presents information regarding the direction of differences for the measures on which a significant difference was found in Table 8.26. This table presents the effect size for each possible two-group comparison and a probability value based on that effect size.

Reassessment #2. It is interesting to note that the group (Classroom + PIE I + PIE II) who received the most parent involvement reported the highest levels of depression symptomatology, significantly more than the Classroom-Only group. However, family cohesion was lowest for the Classroom + PIE I group, significantly more so than either of the other two groups. Logically, the CES-D and cohesion results should not co-occur, suggesting that chance factors may play a role in these findings.

On the chance scale of the CIQ, the results indicate that the Classroom + PIE I + PIE II attributed significantly less of their child's progress to chance than either the Classroom-Only group or the Classroom + PIE I group. In fact, the Classroom-Only and Classroom + PIE I groups did not differ on this measure. Also, the Classroom + PIE I + PIE II group attributed significantly more of their child's progress to professionals than the Classroom + PIE I group, while the Classroom-Only group attributed significantly less of their child's progress to professionals than the Classroom + PIE I group.

A difference was also found on the total score of the PAAT. Both the classroom + PIE I and Classroom + PIE I + PIE II groups reported more appropriate behaviors in teaching interactions with their child. The classroom + PIE I and Classroom + PIE I + PIE II groups were not different on this measure.

Reassessment #3. The significant finding on the CIQ chance subscale reflect those found at Reassessment #2. The findings on the PAAT suggest that the Classroom + PIE I + PIE II group was less frustrated, more appropriately playful, and more appropriately controlling with their child in teaching interactions than the Classroom-Only group. The Classroom + PIE I and Classroom + PIE I + PIE II groups significantly differed on their frustration levels in teaching interactions, with the Classroom + PIE I + PIE II group reporting less frustration. The Classroom + PIE I and Classroom + PIE I + PIE II groups also reported more appropriate control methods in teaching interactions than the Classroom-Only group. These findings on the PAAT are consistent with the PAAT Reassessment #2 results.

Reassessment #4. The results from Reassessment #4 are interesting in that some differences are in areas of child functioning, as reported by the teacher (SPECS), rather than in areas assessing parent perceptions. The results in Table 8.27 suggest an advantage for children whose parents were in the Classroom + PIE I + PIE II group over the other group and for the Classroom + PIE I group, over the Classroom-Only group in the areas of cognition and self-social behaviors. Both intervention groups are favored over the Classroom-Only group in the self-regulation and communication area.

The findings from the frustration scale of the PAAT have shifted from those that occurred at Reassessment #3. At Reassessment #3, the Classroom-Only group reported more frustration in teaching interactions. At reassessment #4, these perceptions of frustration are significantly greater from the Classroom + PIE I group. This drastic change in group significance suggest that either chance factors affected earlier results or that changes in parent attitudes have occurred.

Reassessment #5. The statistically significant findings on the CIQ are slightly different than earlier reassessments but tends to confirm the perceptions at Reassessment #2 and #3. That is, parents in the Classroom + PIE I and PIE II group tend to view themselves and professionals as having a greater impact on their child's progress than either of the two groups. Also, the Classroom + PIE I group appears no different than the Classroom-Only group.

The scores from the Harter Scales indicate that the children in the Classroom + PIE I group view their peer acceptance more favorably than children in either of the other two groups. This finding is not consistent with the results of the Social Skills Rating Scale. This finding may be spurious but will be checked at future reassessments.

Reassessment #6. Only one statistically significant difference was found at this reassessment and it was found on the Social and Communication Scale of the SIB. At this reassessment, children in the Classroom + PIE I groups scored lower than children in either of the other two groups. This difference does not replicate the findings from Reassessments #4 and #5 on this scale and may be a spurious finding. Statistically significant differences found on the Harter Scales at Reassessment #5 were not repeated at this reassessment.

Conclusions

This study investigated the effect on children, parents, and families of placement in a preschool early intervention program supplemented by parent-attended meetings focused on (a) training parents intervention skills, (b) information provision, and (c) social support when compared to the same program without the parent component. Results of this study indicate that the supplemental parent involvement component had a small impact on children's developmental progress immediately after intervention, but that this progress was not maintained over time. Perceptions of family social support were also impacted positively by the parent involvement component immediately following intervention. However, the only aspect of parent or family functioning consistently impacted was that parents who received the parent involvement component were less likely than other parents to attribute their child's developmental progress to chance.

These results of the child and family functioning data do not provide strong support for the inclusion of the type of parent involvement used in this study in early intervention programs. These results do suggest that the type of parent involvement used here may have some limited, immediate effects for both children and families. These results also indicate that this type of parent involvement program was not harmful to either children or families. These results stand in contrast to Shonkoff et al. (1992) who found some negative effects on child outcomes and mixed results on family outcomes based on participation in parent group intervention activities. Both the current study and Shonkoff et al. did find immediate positive effects on family perceptions of social support. Of two other studies which were similar to this one in implementation, the family outcome results are similar to that found in one (i.e., positive outcomes on family perceptions of social support) (Godfrey, DDI Study, this report), but neither the child nor family outcomes are similar to those found in the other (Boyce et al., 1993).

However, longitudinal data suggest that after children leave the early intervention program there may be small advantages for children enrolled in the Classroom + PIE group in terms of classroom placements and on teacher's perceptions of children/parents. These findings speak directly to the need for longitudinal research. The significance of these results at this point in the child's school career can be debated. These data are assessing the perceptions of a person not familiar with the child's early intervention history (a form of social validity) and current classroom placement (which can be influenced by many school and school district variables). The impact of these variables on a child's future functioning are not well known.

Although the current school data have problems due to the changes in sample size from reassessment #4 to #5 to #6, if positive teacher reports continue longitudinally for the parent involvement group, then it suggests some small benefits associated with adding a parent involvement component that are not captured by other measures and that may not have been an expected outcome of this type of intervention. Whether these small benefits warrant the implementation of this type of parent involvement intervention is, also, a debatable point. However, some of the most positive longitudinal outcomes for early intervention programs for children who are disadvantaged have been in areas that were not a direct focus of the early intervention program (Schweinhart & Weikart, 1981; Zigler et al., 1992). These types of longitudinal findings are often taken to support an ecological view of development (Belsky, 1981; Bronfenbrenner, 1979).

Adding a parent involvement component costs about $1,800 per child per year. For this extra expenditure (45% borne by parents in contributed time), there were very limited immediate benefits in terms of developmental outcomes and parent perceptions of social support. Although the evidence for the addition of this type of parent involvement component being cost-effective is not very compelling based on the short-term outcome data, the emerging longitudinal results (albeit somewhat mixed) suggest the need for ongoing cost-benefit analyses. In other words, what are the eventual cost savings from placing fewer children in special education classes and how do those compare to the original expenditures? These analyses are part of an ongoing research project at EIRI.

It is clear that the parent component used in this study is only one type of parent involvement possible from a continuum of parent involvement options, and some interventionists may contend that this parent involvement component did not represent "best practice." This concept of best practice is in itself debatable (Peters & Heron, 1993), but the current involvement program can be examined to determine its positive and negative aspects. The first question that can be asked is, "was the involvement component individualized for the parents involved?" This question can be answered both positively and negatively. Within the group, the focus was on helping the parents provide intervention for their children and providing the parents with information, a still common focus of intervention practice (Mahoney & O'Sullivan, 1990). Parents were not given assessments to determine their specific strengths and needs, but parents chose the specific behaviors of their child they wished to work on and chose the settings in which they were going to implement these skills. Parents also selected, as a group, the focus for the social support component of each meeting. These activities allowed individualization within the group format.

A second area that can be examined is in regard to the mediocre attendance at parent meetings. It is difficult to infer what nonattendance indicates. As noted earlier, mediocre attendance is common in reports of other research that examined parent groups (Baker & McCurry, 1984; Ramey et al., 1992) and attendance is not reported in many studies (White et al., 1992). Nonattendance could indicate dissatisfaction with the group, it could indicate parents attended only when the meetings were addressing a need area, or it could indicate that daily activities interfered with participation; participation which may not have been perceived as necessary because of the child's daily involvement in a comprehensive preschool early intervention program. Anecdotal reports from parents involved in the parent groups (even those who attended infrequently) was uniformly positive and supportive of the continuation of parent groups as an intervention option. Issues regarding attendance/nonattendance need to be studied in greater detail in future research.

The final question in regard to the parent involvement component used in this study is not necessarily in regard to it being best practice. There are probably better designed interventions that could be implemented given more staff and finances. The question might best be stated as, "was this parent involvement component reasonable practice?" From this perspective, the parent involvement component may be efficacious. Recent studies have shown the parents are positive toward the information provision activities when included as part of the group experience (Upshur, 1991) and desire more information from interventionists (Gowen, Christy, & Sparling, 1993). It is an intervention that practitioners can provide and it is not overly expensive to implement. It does not have major impacts on child or family functioning, but it does seem to have a small positive impact. It is also possible that this program had positive benefits in areas such as developing professional contacts or increasing parent feeling of empowerment; areas not measured by this study but ones which could be investigated by other studies.

Another issue to be considered relates to the question of the intensity of this parent involvement component when viewed against the backdrop of the entire array of early intervention services children were provided. It may be overly optimistic for interventionists to expect a program addition that provides such a minimal part of the total intervention program to have a major effect either immediately or longitudinally on outcome variables. The issue of intensity of intervention has been discussed in the literature and it seems clear that minimal increments in program intensity do not and are not necessarily expected to impact on outcomes (Guralnick, 1993; Innocenti & White, 1993; White, 1993). For example, Ramey et al. (1992) provide evidence for the importance of program intensity as it relates to child outcomes in the data from the Infant Health and Development Program (1990). However, upon careful review, it becomes clear that the majority of the intensity data comes from the children's classroom experiences and not from other intervention options (e.g., home visits, parent meetings) provided as a part of the IHDP study. The issue addressed in the present study and not in the Ramey et al. study (1992), is what are the specific effects of just one aspect of the intervention package.

This question of specific effects is an important one to practitioners and to administrators who must decide on issues regarding program design and implementation. Although this study suggests a minimal immediate impact and questionable longitudinal impacts, perhaps this minimal impact is enough to justify its use for program administrators. Also, the issues raised in the early intervention literature regarding the need to examine specific types of questions of "who benefits from what" (i.e., differential benefits of early intervention components depending on subject and family characteristics) are valid (Guralnick, 1993; Innocenti & White, 1993) and cannot be specifically addressed within this one study. However, this study provides answers to some questions that needed to be addressed and opens the research door for explorations into other questions.

The final judgment of the efficacy of this type of parent involvement option will be with the interventionists who must weigh the costs of the program against the outcomes obtained. Regardless of arguments for or against this specific type of parent involvement, this study demonstrates that questions regarding parent involvement can be addressed with methodologically sound experimental studies. This research needs to be systematically replicated and these replications will help to define not only what types of parent involvement "work," but will also help the field of early intervention elucidate its arguments for involving parents. Whatever the role of parents is determined to be, it should be one that is both empirically and logically defensible.

UTAH PARENT INVOLVEMENT STUDY (1986)

Project #9

COMPARISON: Children with Moderate to Severe Disabilities--Center-based intervention plus parent involvement versus center-based intervention only.

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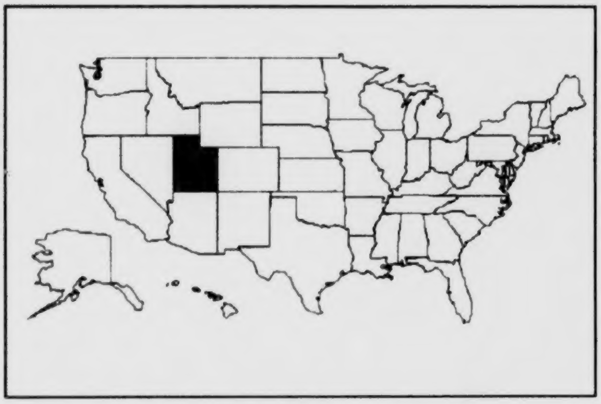
EIRI COORDINATOR: Michael K. Godfrey

LOCATION: Salt Lake City, Utah

DATE OF REPORT: October 1, 1994

Rationale for Study



The belief that early intervention programs that involve parents are more effective than programs that do not is widely accepted (Bronfenbrenner, 1974; Garland, Swanson, Stone, & Woodruff, 1981; Johnson & Chamberlin, 1983; Karnes & Lee, 1978; Lazar, 1981; Parker & Mitchell, 1980; Simeonsson et al., 1982). Part of this belief is founded upon the principles of contextualism. If parents are involved with their child's early intervention, they will learn the techniques used in the setting and can apply them at home. Likewise, the early intervention setting can learn the techniques used at home and apply those techniques in the classroom. The bi-directional influences result through the collaboration of teachers and parents and theoretically aid the developing child. Parent involvement in early intervention settings also helps families by providing a support group and a method of information sharing. Because of these aids, parent involvement has become an integral part of early intervention programs.

As the field of early intervention for children with disabilities developed, parent involvement became a part of many intervention programs (White, Mastropieri, & Casto, 1984). Through the years, parents were involved in intervention programs in a variety of ways. The most common method has been to teach parents to stimulate and encourage the development of their child's abilities (White et al., 1992). These instructional programs often provided a parental support network with professionals and other parents, presented general child development principles, and provided information about available intervention services (McConachie, 1986). The belief that early intervention programs are more effective if parents are involved continues even today. Public Law 99-457, which requires every child between birth and age three who is served and who has a disability to have an Individualized Family Service Program (IFSP), demonstrates the government's support of parent involvement in the intervention process.

In spite of the widespread belief that early intervention programs for children with disabilities are more effective when parents are involved, there is little empirical evidence to support this view (Casto & Mastropieri, 1986; White et al., 1992). Anecdotal reports and research with some methodolgical flaws have provided much of the evidence for these beliefs. Most studies use quasi-experimental or cross-sectional designs that necessarily omit comparison groups, random assignment, or pre- and posttesting. While much can be learned from these studies, true experimental designs can contribute to more methodologically sound research. Besides the limitations of the designs, the effects have usually been limited to short-term investigations on childrens intelligence or development. Long-term investigations involving both the parents and or families have, regrettably, been limited.

Therefore, the purpose of this study was to investigate the immediate and long-term effects of adding a parent involvement component to an existing early intervention program. The parent involvement program for this study was designed to a) involve parents in providing intervention activities for their children, b) assist parents in working with interventionists, and, c) provide a support group through the medium of the instructional sessions that includes the instructors and other parents. The effects on children with their families were examined immediately following the parent sessions and annually thereafter.

Review of Related Research

Historically, the involvement of parents in their children's education has been considered a vital component of successful programs for both typical and disadvantaged children (Clarke-Stewart, 1982). Founded upon a belief in the importance of parent-child interaction and built on the idea that families were the primary influence for children's values and behaviors, parent involvement activities have been viewed as a way to solve a variety of societal problems by many social scientists, practitioners, and advocates. Therefore, parent involvement activities became an important part of the government's social policy. The Head Start program, for example, which served as a guide for many subsequent early intervention projects, included a parent involvement component as an integral part of its activities. Bronfenbrenner's (1974) report on early intervention programs was especially influential in arguing that early intervention with children who are disadvantaged was more effective when parents were involved in the program. This argument asserted that increased participation of parents provided the value change that led parents to encourage and reinforce their children's learning activities. Lazar's (1981) commonly cited analysis of 14 studies of early intervention for children who were disadvantaged reaffirmed this contention by stating that direct participation of parents was significantly related to positive program outcomes. Over the years, many have argued that parent knowledge aids child development. From their review of literature Dichtelmiller et al. (1992) concluded that "differential levels of parent knowledge make a small but significant contribution to the child's development" (p. 212).

The benefits associated with parent involvement are believed to be well established with all children, but most of the evidence comes from studies done with children who are disadvantaged. These benefits include: gains in children's relative intelligence; fewer special educational placements (Haskins & Adams, 1982); children's increased sociability and cooperation (Clarke-Stewart, 1982), increased infant responsiveness; improvement in children's school performance; and positive effects on maternal behavior (e.g., more facilitative language, flexible child-rearing patterns, awareness of parental role as educator) (Powell, 1986). It is not known whether these benefits hold true for children with disabilities.

As early intervention for children with disabilities increased, practitioners believed that parent involvement increased the efficacy of the intervention, following the philosophy of the intervention with disadvantaged children. Foster, Berger, and McLean (1981, p. 55) summed the general acceptance of the importance of parent involvement by the early intervention community when they noted that, "Parent involvement is a good idea that has become an essential and often unquestioned component of intervention programs for young handicapped children." Likewise, White, Bush, and Casto (1985-86), in their extensive review of reviews of early intervention effectiveness research, found parental involvement the most frequently cited characteristic thought to contribute to the effectiveness of early intervention programs.

The belief that early intervention programs for children with disabilities is more effective if parents are involved continues today. Public Law 99-457, which established incentives for early intervention programs, requires every child who is being served, age birth to three, to have an Individualized Family Service Program (IFSP). This requirement underscores the need to have parents and other family members substantially involved in their child's early intervention program.

In spite of the widespread belief that early intervention programs for children with disabilities will be more effective if parents are involved, the hypothesis has seldom been systematically tested using well-controlled research. As White et al. (1992) concluded in their extensive review of the research that investigated the benefits of involving parents in early intervention programs:

> *...Much of the perception that parent involvement is beneficial has been based on anecdotal reports and poorly designed research....Carefully designed research should help us to balance our hopes with reality.* (p. 119)

Design elements (e.g., comparison groups, random assignment, pre- and posttesting) that help ensure sound research have often been missing (Guralnick, 1991; White et al., 1992). Treatment verification (i.e., processes to ensure that the desired intervention took place) has seldom been included in the research design (Guralnick, 1991).

Also, much of the research has provided only indirect evidence as to the effectiveness of parent involvement. Most research has been concerned with demonstrating the overall effectiveness of a program. When several intervention components (e.g., length, intensity, program content, and parent involvement) are included, it is impossible to sort out which components caused which effects (Clarke-Stewart, 1982).

Outcome variables have also been limited. Thus far, child development or IQ has been the predominant outcome variable (Casto & Mastropieri, 1986; Dunst, Snyder, & Mankinen, 1989). Studies have not been concerned with family effects, although many researchers have argued that the family or parent benefits of parent involvement are greater than those demonstrated by the target child (Dunst, 1986). Reviewers have also argued for the investigation of long-term effects (Innocenti & White, 1993).

Several studies were identified by White and his associates (1985-86) that investigated whether early intervention programs for children with disabilities which involved parents were more effective than similar intervention programs which did not involve parents (Barnett et al., 1988; Boyce, 1991a, b; Henry, 1977; Innocenti, 1991;

Miller, 1981; Minor, Minor, & Williams, 1983; Scherzer, Mike, & Ilson, 1976). Most of those studies suffered from serious methodological weaknesses (White et al., 1992). The majority found statistically non-significant results attributable to parent involvement, with the studies which were rated as the most carefully controlled finding the smallest effects attributable to parent involvement. In recommending that more research on this important topic was needed, White et al. (1992) pointed out that persuasion and politics concerning the benefits of parent involvement in early intervention programs have gone far beyond the available scientific evidence. Clearly, the need for additional research is indicated.

This study was designed to respond to the need for further research in this area. The hypothesis being tested was that a center-based early intervention program for young children with moderate to severe disabilities would be more effective for participating children and families if parents were involved than a similar center-based program with minimal parent involvement. To test that hypothesis, an existing high-quality, center-based intervention program which did not offer a group parent instruction/involvement program was identified and children were randomly assigned to one of two groups. In both groups, children participated in the same center-based early intervention program, but in one group parents were invited to participate in additional instruction through group classes and individual assignments.

The choice of the particular parent involvement program was determined by a review of the literature. Terms like "parent involvement" are so broad they can refer to a number of very different types of activities. For example, some of the parent involvement literature focuses on the partnership between families and schools (e.g., Epstein, 1990; Epstein & Kroft, 1989). Other literature focuses on programs designed to teach effective parenting and child-rearing skills (e.g., Gamson, Hornstein, & Borden, 1989; Nye, 1989). Still others focus on the appropriate role of parents in the normal developmental process (e.g., Vartuli & Winter, 1989; White, 1975). Although all of these are important aspects of the broad area of parent involvement, the focus of this study was on parent involvement in early intervention programs as defined by McConachie (1986) in which parent involvement includes one or more of the following components.

- Teaching parents specific intervention skills to assist them in becoming more effective change agents with their child.
- Providing social and emotional support to family members.
- Exchange of information between parents and professionals.
- Participation of parents as team members (e.g., in assessment or program planning).
- Development of appropriate parent/child relationships.
- Assisting parents in accessing community resources.

A similar description of parent involvement in early intervention is given by Peterson and Cooper (1989).

Using such definitions, White et al. (1992) did a content analysis of 172 early intervention research studies which had involved parents in a substantial way. Based on that study, they concluded parents were most frequently involved as trainees to care for, stimulate, and teach their child. The training typically included training on how to best manage the child and/or how to engage the child in activities promoting optimal development and learning. A substantial number of the studies also provided parents with social and emotional support and taught them basic concepts about child development. Because this was the way in which existing early intervention research most frequently defined parent involvement, it was decided to make such a program the focus of the parent involvement component being tested in this research.

Overview of Study

The purpose of this study was to investigate the effectiveness of adding a specific parent involvement component with a parent-as-intervener focus to an ongoing center-based intervention program to determine if there were benefits for child development or family well-being. Specifically, based on the directions from the literature discussing goals of parent involvement programs, we investigated whether adding this particular parent involvement component influenced (a) child development, (b) later school placement, (c) parental interaction behaviors with child, (d) parents' perceptions of social support, (e) parenting stress, and (f) general family functioning (e.g., family cohesion and adaptability).

To investigate this question, two randomly assigned groups from a sample of 56 preschool children with moderate to severe disabilities were compared. The children were in a 3-hour-per-day, 5-days-per-week, center-based preschool intervention program offered at a private, non-profit agency in Salt Lake City, Utah. The parents of one group attended 15 weeks of parent instruction; the parents in the other group did not. These groups will be referred to as the center-based with parent involvement group and the center-based only group. The curriculum for the parent involvement group sessions was based on the Parent Involvement in Education program (PIE) (Pezzino & Lauritzen, 1986). It is important to note that in this center, as in most centers, all parents were somewhat involved through IEP meetings, visiting with the teachers when they brought and picked up their children, and occasionally helping in the classrooms. Assessments, including measures of child development and family functioning, were completed prior to the parent instruction, after the instruction was completed (seven months later), and annually thereafter for seven years.

Methods

Subjects

Preschool children with moderate to severe disabilities who were participating in an early intervention program were considered for inclusion in this study. The preschool intervention program was offered through a private, non-profit agency under the auspices of the state agency. Developmental Disabilities, Inc. (DDI) was located in Salt Lake City, Utah and provided these services before P.L. 99-457 became law. The Battelle Developmental Inventory was used as a screening instrument to determine children's eligibility for services at the time. Children scoring at least 1½ standard deviations below the mean in two or more developmental areas, or 2 standard deviations below the mean in one area qualified for services at the center.

Recruitment. Parents of eligible children were sent a letter inviting them to participate in the research. The letter explained the study, including the random assignment procedures. No services were withheld if parents did not want to participate. Sixty-seven parents responded; nine were unable to participate due to reasons such as lack of transportation, illness, etc. Thus, 58 subjects were administered an initial assessment battery. Two left school soon after the assessment, leaving a sample of 56 children. A variety of disabilities were represented within this group of children, including general developmental delay (n = 27), Down syndrome (n = 12), cerebral palsy (n = 7), multi-disabled (1), and motor, cognitive, language, or health delay (n = 9). The average developmental quotient for the group was 58. (Each developmental quotient was computed by dividing the BDI [Newton, Stock, Wnek, Guidubaldi, & Svinicki, 1984] age equivalent score by their chronological age and multiplying the quotient by 100.)

Assignment to groups. Prior to the initiation of treatment, subjects were randomly assigned to one of two treatment groups: the center-based with parent involvement, or the center-based only group. Before being randomly assigned the children were stratified by age, developmental level, and their teacher's rating of parent motivation. Parents agreed in advance to the random assignment. Subject recruitment and assignment was completed in November, 1986.

Demographic characteristics. Children ranged in age from 23 to 61 months, with an average age of 42 months at the beginning of the intervention. Most of the parents were in their late twenties or early thirties. As a group, the parents were fairly well educated with the average educational level for both mothers and fathers being more than 13 years. Almost all of the families were Caucasian, and the demographic data indicated that most of them would be considered middle class. Typically, the children were living with both parents and a majority of the mothers (66%) reported no employment outside their home. Parents typically reported having 3 children, including the subject. Table 9.1 presents demographic comparisons (based on t-tests) of the center-based only and the center-based with parent involvement groups at the initial assessment.

These results indicated that the two groups were generally comparable in terms of demographic characteristics. Of the 19 variables measured, 17 showed no statistically significant difference. In the center-based with parent involvement group, more families reported having two parents in the home (p value = .04, ES = .47), and more families had other children with disabilities (p value = .02, ES = 1.0).

Attrition. Two subjects dropped out between the time of the initial assessment and reassessment #1. One subject cited the birth of a new baby and a language barrier (the subject was a recent immigrant) as reasons for dropping out of services altogether. The other subject dropped out of the study because the mother decided to withdraw her child from services at the intervention center. Thus, the sample at reassessment #1 consisted of 56 subjects with 28 in each group.

Forty-two families participated in at least part of reassessment #2; 14 families did not participate. The reasons for non-participation included family problems, moving out of state, and the inability of the staff to locate the subjects. (Standard procedure for locating lost subjects was to [1] contact next of kin, and [2] send a certified letter. For these cases, neither procedure proved successful.) Analyses were performed to determine if those children who were not tested at reassessment #2 were any different on the assessment and demographic variables from those who were tested. A 2 X 2 analysis of variance was used to determine the differences between the groups. P-values and effect sizes are reported in Table 9.2

Table 9.1

Comparison on Key Demographic Variables of the Center-Based Only and Center-Based with Parent Involvement Groups in the 1986 Parent Involvement Study

	Center-Based			Center-Based + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES^
• Age of child in months as of 11/15/86	43.0	10.5	28	41.7	10.6	28	.62	-.12
• Age of mother in years	33.4	5.8	28	31.9	5.6	28	.33	-.26
• Age of father in years	35.9	6.2	27	33.8	6.4	28	.23	-.34
• Percent Male*	57.1		28	42.9		28	.29	-.26
• Years of Education--Mother	13.8	1.7	28	13.5	1.5	28	.51	-.18
• Years of Education--Father	13.8	2.1	28	14.0	2.1	28	.66	.10
• Percent with both parents living at home*	78.6		28	96.4		28	.04	.47
• Percent of children who are Caucasian*	92.9		28	100.0		28	.16	.27
• Hours per week mother employed	8.4	13.7	26	6.4	10.8	28	.55	-.15
• Hours per week father employed	42.8	15.5	21	36.6	18.9	26	.23	-.40
• Percent of mothers employed outside the home*	42.9		28	28.6		28	.27	-.27
• Percent of fathers employed as technical managerial or above*	61.5		26	46.2		26	.28	-.28
• Total household income'	$21,785	$12,728	28	$23,314	$13,684	27	.67	.12
• Percent with mother as primary caregiver*	96.4		28	100.0		28	.32	.15
• Percent of children in daycare more than 5 hours per week*	10.7		28	3.6		28	.31	-.22
• Number of siblings	2.1	1.7	28	2.3	1.1	28	.71	.12
• Number of siblings with disabilities	.1	.3	28	.4	.7	28	.02	1.00
• Percent with English as primary language*	96.4		28	100.0		28	.32	.15
• Maternal PPVT (standard)¹	99.6	18.0	28	99.3	17.1	27	.97	-.02

* Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scores at "0."

' Income data were converted from categorical to continuous data by using the midpoint of each category.

^ Effect size is defined here as the difference between the groups (center + PIE minus center) on the ANCOVA scores, divided by the unadjusted standard deviation of the center-based intervention group. (See Glass, 1976; Tallmadge, 1977; & Cohen, 1977, for a more general discussion of the concept of Effect Size.) The sign of ES only indicates direction of difference; no value judgement is intended.

¹ Maternal PPVT measures mother's receptive vocabulary. It correlates highly with IQ measures. This measure was taken at Reassessment #1, but was considered a assessment variable.

for the study status main effect. The assessment scores of those tested and those not tested at reassessment #2 were very similar; therefore, the attrition did not appear to influence the reassessment results. The means and standard deviations for the group assignments by study status are listed as a reference for the reader. There were no significant main effects for group assignment nor for the interaction between the groups and study status.

At reassessment #3, substantial efforts were made to retrieve subjects not tested at reassessment #2; 51 children and their families completed the measures (25 in the center-based with parent involvement group and 26 in the center-based only group), leaving 5 who were not tested. Two lived in states where testers could not be located. Two mothers who had refused to participate at reassessment #2 again refused to be reinstated, and one was not located.

Table 9.2

Comparison on Assessment Variables of Subjects Who Withdrew from Study With Those Who Completed Reassessment #2 in the 1986 Utah Parent Involvement Study

		Center-Based			Center-Based + PIE			Study Status							
								In Study			Out of Study				
Variable		$\bar{x}$	SD	n	$\bar{x}$	SD	n	$\bar{x}$	SD	n	$\bar{x}$	SD	n	p* Value	ES**
Age at Assessment	IN	42.4	11.9	20	41.6	11.6	20	42.0	11.6	40	43.1	7.1	16	.73	-.09
	OUT	44.5	6.1	8	41.7	8.2	8								
BDI Total Raw Score	IN	286.2	72.3	20	296.5	68.5	20	291.3	69.7	40	260.4	98.0	16	.19	.44
	OUT	254.8	75.1	8	266.0	121.9	8								
Parenting Stress	IN	255.7	53.6	20	257.2	31.7	19	256.4	43.8	39	250.4	37.6	16	.63	.14
Index - PSI	OUT	251.3	36.4	8	249.5	41.2	8								
Mother's Education	IN	13.9	1.5	20	13.5	1.5	20	13.7	1.5	40	13.6	1.9	16	.96	.07
	OUT	13.6	2.2	8	13.6	1.8	8								
Income	IN	$22,325	$13,496	20	$23,100	$11,666	20	$22,712	$12,458	40	$22,066	$15,161	15	.87	.05
	OUT	$20,437	$11,296	8	$23,928	$19,490	7								
Family Adaptability	IN	25.5	5.9	20	26.1	6.3	20	25.8	6.0	40	23.3	5.3	16	.16	.42
FACES III	OUT	22.0	5.2	8	24.6	5.3	8								
Family Cohesiveness	IN	38.1	9.0	20	39.2	4.9	20	38.6	7.2	40	38.6	4.8	16	.99	.00
FACES III	OUT	37.4	5.6	8	39.9	3.9	8								
Family Resources	IN	113.2	16.9	20	113.3	16.4	19	113.2	16.4	39	114.8	21.8	16	.78	-.10
FRS	OUT	117.8	22.0	8	111.8	22.6	8								
Family Support	IN	27.9	10.8	20	28.2	10.2	20	28.0	10.4	40	30.3	11.9	16	.48	-.22
FSS	OUT	29.4	12.8	8	31.3	11.8	8								

$$ES = \frac{\bar{X}_{in} - \bar{X}_{out}}{SD_{in}}$$

* The p value and ES are based on comparison of study status (i.e., in study, those who were tested at that reassessment versus out of study, those who were not tested at that reassessment). The sign of ES only indicates direction of difference; no value judgment is intended.

Participation remained high at reassessment #4 with 52 children and their families tested. All four children who were not tested were from the parent involvement group. Two of these had declined to participate since reassessment #1, one died in December, 1989, and one child's mother declined to participate this year.

Fifty-three children were tested at reassessments #5, #6, #7, and #8. Those not tested included the two who had not participated since Reassessment #1 and the one who died after reassessment #3. One child's scores were not included in the analyses of achievement (when the Woodcock-Johnson Revised Achievement [WJ-R] was used) because she could not adequately see the test materials.

Comparison analyses of subjects tested at the third, fourth, and fifth reassessments with those not tested at the same reassessment were performed to determine if those children who dropped out of this study were any different on the various assessment and demographic variables from those who remained in the study. None of these analyses revealed statistically significant differences.

Intervention Programs

The purpose of this study was to compare a center-based only intervention group with a center-based intervention group whose parents participated in a particular type of parent involvement. A description of these treatments follows. All children were involved in the center-based early intervention program. The children in both groups were scattered among the classrooms at the center. Classroom teachers may have known their students were in this study, but they were "blind" as to the group assignment. Their lack of knowledge was an essential part of the experimental design. Had they known which intervention group a specific student was in, they may have inadvertently treated that student differently. The differential treatment would have added a confounding variable that may have been responsible for the results instead of the intervention.

Center-Based Intervention Program. Most of the children attended a preschool program three hours per day, five days per week. A few of the children from both groups were involved for part of the year in other intervention programs at the same center, including: a 4-day-per-week preschool, individual therapy (primarily for infants), and a transition program designed to move children from the individual therapy to the preschool program. Children who participated in these other programs (less than 20% of each group) were equally represented in the center-based and the center-based with parent involvement groups.

In the preschool program, each group of 9-12 children was instructed by a special education teacher who was assisted by a paraprofessional aide. The average number of children in the classrooms was 9.75. During a typical day, children were instructed in developmental areas such as motor, speech/language, self help, cognitive, and social skills. Instructional activities were developed from comprehensive assessments. Items were drawn from a number of curricula with no single, specific commercial curriculum being used to determine intervention goals and activities. Children received services in different educational formats (i.e., large group, small groups, and one-to-one) according to their individual needs that had been prioritized on IEPs developed by the parents, the special education teacher, and a motor and/or language therapist. The teachers were certified in special education, while their aides were not. Certified language and motor therapists provided individualized language and motor instruction to the children. These therapists also assisted the teachers and their paraprofessional aides in implementing the activities. Some parents in both treatment groups helped occasionally in the classroom, doing various tasks as directed by the teacher. Parents also had contact with the teachers when they brought or picked up their children from school and during the IEP consultations.

Center-Based With Parent Involvement Intervention Program. Children in this group attended the same center-based program described above. Parents of children in this group participated in an education program based on the Parents Involved in Education (PIE) (Pezzino & Lauritzen, 1986) instruction package which was designed to improve the parents' skills in teaching their children and to help the parents be more competent partners in the intervention process. This type of parent involvement program was chosen because it was typical of the parent involvement programs most frequently described in the literature.

The PIE instructional modules were designed to provide parents with a systematic conceptual and hands-on experience in areas such as child development, observation and recording, targeting intervention behaviors, teaching processes, decision making, and communicating with professionals. The training format consisted of small group lecture, discussion, and demonstration. The curriculum included the following topics: (1) introduction and overview, (2) objective observation of child behavior, (3) defining and measuring behavior, (4) principles of behavior management, (5) analyzing behavior chains, (6) theories of child development, (7) testing and assessment, (8) criterion-referenced assessment, (9) developing learning objectives, (10) P.L. 94-142 and IEPs, (11) intervention strategies, (12) factors related to teaching success, (13) practice teaching session, (14) determining appropriate interventions, (15) communicating with professionals, (16) stress management, and (17), review, comments, concerns, and questions.

PIE instructional sessions were taught either by a social worker or the director of the intervention center. Average group size consisted of nine parents. Instruction sessions consisted of 15 ninety-minute sessions, held weekly over a period of four months. In addition to these sessions, parents were asked to practice the training activities at home with their children. They were asked to choose a target behavior for the child (such as a self-help or behavioral skill; e.g., compliance, dressing, etc.), implement an intervention program, and measure progress by comparing successful completion of the task before and after the intervention. A part of each PIE instructional session was designed to provide an opportunity for parents to form support networks and discuss challenges associated with parenting a child with a disability.

Treatment Verification

A number of procedures were implemented to verify that the intervention program occurred as planned. Child attendance at the center-based program was recorded daily and sent to EIRI on a monthly basis. As shown in Table 9.3, child attendance exceeded 65% for both the parent involvement and comparison groups. Attendance of parents at the PIE sessions was recorded weekly and these data were sent to EIRI on a monthly basis. The parents, on average, attended 9 of the 15 sessions; one parent attended all 15 sessions and one parent did not attend any.

Parent ratings of the intervention services provided additional information about the nature of the treatment delivered to children. Parents rated seven aspects of the intervention program on a 1- (poor) to 4- (excellent) scale. Parents in both groups were similarly satisfied with the services with average ratings of almost 3.5 in each group. The only statistically significant ($p \le .10$) differences[1] on parent ratings of services were that at Reassessment #1, soon after the PIE instruction was completed, parents in the center-based with parent involvement group were more satisfied with their opportunity to participate ($p = .09$) and at Reassessment #2, the center-based only group rated their ability to communicate with program staff higher ($p = .08$).

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[1] *As discussed further in the Results section, alpha for all statistical tests was set at $p \le .10$ in order to increase statistical power and balance Type I and Type II errors.*

Table 9.3

Comparison of Treatment Verification Variables for Center-Based Only and Center-Based with Parent Involvement Group for 1986 Parent Involvement Study

	Center-Based Program			Center-Based + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p** Value	ES*
REASSESSMENT #1								
•Child's school attendance (%)	68.8		28	65.6		27	.64	-.02
•Parent Attendance at PIE Instruction	0.0	(0.0)	28	8.7	(4.3)	28		
•Test of Parent Knowledge'	14.0	(5.5)	28	18.0	(5.5)	28	.01	.73
•Parent ratings of educational services*								
Staff	3.4	(.5)	28	3.4	(.6)	27	.91	.00
Communication	3.3	(.6)	28	3.4	(.6)	27	.61	.17
Child's goals/activities	3.2	(.6)	28	3.3	(.6)	27	.61	.17
Opportunity to participate	3.3	(.7)	28	3.5	(.5)	27	.09	.29
Range of services	3.0	(.7)	28	3.2	(.7)	27	.23	.29
Program in general	3.2	(.6)	28	3.3	(.7)	27	.48	.17
Child's progress	3.3	(.5)	26	3.1	(.6)	23	.38	-.40
REASSESSMENT #2								
•Test of parent knowledge'	15.0	(5.9)	20	19.1	(4.8)	17	.03	.69
•Parent rating of educational* services								
Staff	3.5	(.6)	19	3.5	(.7)	21	.81	.00
Communication	3.7	(.6)	19	3.4	(.8)	20	.08	-.50
Child's goals/activities	3.5	(.5)	19	3.4	(.5)	21	.78	-.20
Opportunity to Participate	3.6	(.6)	19	3.7	(.5)	21	.61	.17
Range of services	3.0	(.7)	19	3.2	(.8)	21	.43	.29
Program in general	3.5	(.5)	19	3.4	(.9)	21	.84	-.20
Child's progress	3.5	(.5)	20	3.5	(.8)	19	.86	.00
REASSESSMENT #4								
•Test of parent knowledge	14.8	(6.1)	27	17.4	(6.3)	24	.14	.43

' All parents took a test based on the PIE curriculum that was taught to the parent involvement group. Higher scores indicate more correct answers.

* Data are based on Parent Satisfaction Questionnaire Scores (range 1-4). Higher scores indicate better ratings.

$$ES = \frac{\text{Center-Based + PIE } \bar{x} - \text{Center-Based } \bar{x}}{\text{Center-Based SD}}$$

Interviews conducted with parents at the time of the second reassessment revealed that almost all were satisfied with the center-based services they received. Only one parent of the 40 interviewed reported leaving the center's intervention program because of dissatisfaction with the services. Several reported problems with transportation (6 parents) or scheduling of the child's classes (3 parents). The most frequently cited service mentioned as most helpful by these parents was speech therapy.

At the second reassessment, parents who participated in the PIE program were asked specific questions about their classes. (Seventeen of the twenty parents who participated in the second reassessment completed these questionnaires.) The majority (14) of these 17 parents found the center-based program more valuable than the PIE instruction. However, most reported less stress in their lives after the instruction (11 parents) or no change in stress (2 parents). Fourteen of the 17 parents reported that they felt the PIE program positively influenced their interactions with their children, with these parents claiming greater objectivity and more effective behavior management techniques. Fifteen of the 17 parents were satisfied with the parent involvement package and the information provided. Two parents did not report being satisfied. One was indifferent towards the program and attributed her indifference to her poor attendance, and the other parent did not feel the information was useful.

Treatment effects could be influenced by using more than one PIE instructor. Instructor effects have been previously noted in the parent involvement research literature (Hoover-Dempsey, Bassler, & Brissie, 1987). Therefore, an additional analysis was completed on the reassessment data which compared the effect of parenting group instructor on outcome measures for the parenting group. (Two instructors taught the parent workshops; one had one class of 9 parents while the other had two classes which also consisted of 9 parents each.) Table 9.4 presents these results. No statistically significant effect due to instructors was evident on child or family functioning measures. Thus, having different instructors for the PIE instruction did not appear to have affected the comparison of treatment intervention.

Table 9.4

Comparisons of Effect Due to Instructor at Reassessment #1 in the 1986 Parent Involvement Study

	Instructor A			Instructor B			
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value
•Battelle Total (DQ)	56.45	14.3	9	66.02	14.5	18	.12
•CES-D (depression)	29.33	5.68	9	35.44	13.73	18	.22
•PSI--Child	114.67	18.90	9	122.61	17.07	18	.28
•PSI--Other	131.22	14.26	9	137.28	28.75	18	.47
•FACES--Adaptability	3.89	2.37	9	5.50	6.73	18	.37
•FACES--Cohesion	6.22	9.43	9	8.22	7.16	18	.54

A structured site visit during the initial year of the project was conducted by the research staff to make sure that the interventions were occurring as planned. The results of that site visit (a detailed report of which is available from EIRI) found that all the children participated in essentially the same center-based program, with the major difference being that the parents of the children in the center-based with parent involvement group received the additional parent involvement component and the parents of the children in the other group did not.

The treatment verification procedures described above were useful in deciding whether the alternative intervention programs were delivered as planned. Knowing that the interventions differed in the ways intended increases the confidence that differences in outcomes, if found, were related to the differences in treatment and not to other factors. In a study such as this one it is also important to ascertain whether other historical factors occurred outside of the treatment which might have affected the results. A discussion of these follows.

Contextual Factors

The alternative early intervention programs under investigation were not the only factors which could have influenced the development of these children or the functioning of their families. Other factors, such as the health of the children, changes in the family's living situations, the families' resources, and other family stresses might have influenced child development and family functioning. Additionally, other intervention services purchased by the parents might have affected the outcome scores. To the degree that these contextual factors were equal for children in both groups, differences in outcomes can be more confidently attributed to the differences between the treatments. However, if differences in these contextual factors exist for children between the groups and they differ in outcome measures, we cannot be sure whether the differences in outcome measures are the result of differences in treatments or the differences in the contextual factors. Therefore, a concerted effort was made to monitor the effects of a number of contextual factors.

Annually, parents completed a demographic survey about their living situation and a child health survey. Key demographic factors that are subject to change are listed in Table 9.5. Throughout the reassessments, the center-based with parent involvement group included more families in which both the mother and father were present in the home and had more children needing special educational services than did the center-based only group, echoing the initial assessment differences. Mean income of the groups increased over time, but remained comparable to each other across reassessments. Mothers in the center-based only group tended to work more hours per week than mothers in the center-based with parent involvement group, but the difference was only statistically significant (p = .07) at reassessment #4.

As part of the annual child health questionnaire, parents compared their child's general health to other children on a scale of "1" (poor health in comparison to others) to "3" (better health in comparison to others). The mean scores and standard deviations across reassessments indicated that the health of the children in the two groups was very similar and that most of the children had average health when compared to other children.

Table 9.5

Comparison of Contextual Variables for Center-Based Only and Center-Based With Parent Involvement Groups for 1986 Utah Parent Involvement Study

	Center-Based Program			Center-Based + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p** Value	ES*
REASSESSMENT #1								
•Child Health	1.9	(.7)	28	1.9	(.7)	27	.68	.01
•Demographics								
% of children living with mother & father	78.6		28	96.3		27	.05	.46
Mother's employment hrs/week	8.8	(13.9)	25	5.1	(9.8)	26	.28	-.27
Annual income	$21,785	($12,728)	28	$23,129	($13,729)	27	.71	.11
% of siblings receiving special education services	7.4		27	50.0		26	.01	.94
•Family Variables								
Family resources (FRS)[4]	112.4	(23.6)	28	111.3	(19.1)	28	.85	-.05
Family life events (FILE)[4]	10.7	(7.6)	28	12.1	(6.7)	28	.47	.18
•Additional Services								
Speech Therapy: % receiving 1 hr/month or more	7.1		28	10.7		28	.65	.10
Physical/occupational therapy % receiving 1 hr/month or more	7.1		28	10.1		28	.65	.09
Daycare % received less than 5 hrs/week	100.0		28	89.0		28	.40	-.37
•DDI Teacher Rating of Parents[5]								
Attendance	2.6	(.8)	26	2.8	(.4)	24	.24	.25
Support	2.3	(1.0)	26	2.5	(.6)	24	.40	.20
Knowledge	2.2	(1.0)	26	2.6	(.5)	24	.07	.40
REASSESSMENT #2								
•Child Health	1.9	(.6)	19	2.0	(.6)	21	.75	.17
•Demographics								
% of children living with mother & father	76.2		21	100.0		18	.03	.58
Mother's employment hrs/week	8.5	(15.6)	20	2.6	(6.4)	19	.13	-.38
Annual income	$23,785	($15,895)	21	$25,631	($12,029)	19	.68	.12
% of Siblings receiving special education services	23.8		21	78.9		19	.03	1.13
•Family Variables								
Family resources (FRS)[4]	115.9	(22.7)	21	114.0	(19.2)	20	.77	-.08

(continued)

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* $$ES = \frac{\text{Center-Based + PIE Adj.}\bar{x} - \text{Center-based Adj.}\bar{x}}{\text{Center-Based SD}}$$

** The p value and ES are based on comparison of study status (i.e., in study, those who were tested at the reassessment versus out of study, those who were not tested at that reassessment). The sign of ES only indicates direction of difference; no value judgment is intended.

[5] Data are based on teacher rating of parents' attendance, support, and knowledge range (1-3). Higher scores indicate better ratings.

[4] Analyses for the FRS are based on raw scores indicating number of supports on resources indicated by the family as being available. Higher scores and positive ESs are considered better. Analyses for the FILE are based on raw scores. Lower scores represent less stress and are considered better.

Annually, parents completed an additional services form which described other types of intervention or additional services the child and family received. At Reassessment #5, this was replaced with an interview.

The form asking for children receiving special education services in the home was changed from percent of siblings receiving special education services to number of children in home with delays or disabilities reassessment #5.

Analyses for the Holmes-Rahe are based on raw scores. For both family stress and negative events lower scores represent less stress and are considered better.

Table 9.5 (continued)

Comparison of Contextual Variables for Center-Based Only and Center-Based with Parent Involvement Groups for 1986 Utah Parent Involvement Study

	Center-Based Program			Center-Based + PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p** Value	ES
REASSESSMENT #3								
•Demographics								
% of children living with mother & father	80.8		26	95.8		24	.11	.39
Mother's employment hrs/week	9.9	(15.5)	26	4.5	(8.5)	24	.13	-.35
Annual income	$25,923	($15,052)	26	$25,458	($13,299)	24	.91	-.03
% of siblings receiving special education services	23.1		26	83.3		24	.02	1.32
•Family Variables								
Family resources (FRS)'	117.5	(20.8)	26	117.8	(15.8)	24	.96	.01
REASSESSMENT #4								
•Child Health	2.0	(.5)	28	2.1	(.7)	24	.60	.20
•Demographics								
% of children living with mother & father	75.0		28	78.3		23	.79	.06
Mother's employment hrs/week	12.6	(17.6)	25	5.1	(9.3)	22	.07	-.43
Annual income	$27,038	($16,617)	26	$26,478	($17,045)	23	.91	-.03
% of siblings receiving special education services	17.9		28	82.6		23	.01	1.47
•Family Variables								
Family resources (FRS)'	118.5	(17.9)	28	115.4	(18.1)	24	.54	-.17
•Additional Services								
Speech therapy: % receiving 1 hr/month or more	0		28	0		23	1.00	0
Physical/occupational therapy: % receiving 1 hr/month or more	0		28	0		23	1.00	0
Daycare: % received less than 5 hrs/week	100		28	100		23	1.00	0
REASSESSMENT #5								
•Child Health	2.0	(.5)	28	2.1	(.7)	25	.50	.20
•Demographics								
% of children living with mother & father	80.8		26	96.0		25	.10	.40
Annual income	$29,537	($13,975)	27	$32,160	($19,048)	25	.57	.19
Number of children in home with delays or disabilities'	1.1	(.4)	28	1.5	(.8)	25	.01	1.00
•Family Variables								
Family resources (FRS)'	115.3	(20.0)	28	119.1	(16.8)	24	.46	.19
Family stress (Holmes-Rahe)'	149.5	(94.1)	28	199.6	(152.4)	24	.15	.53
Family negative events' (Holmes-Rahe)	35.9	(48.2)	28	37.2	(51.5)	24	.92	.03
•Additional Services'								
Speech therapy: % receiving 1 hr/month or more	3.6		28	20.0		25	.07	.45
Physical/occupational therapy: % receiving 1 hr/month or more	17.9		28	16.7		25	.59	-.02
Total school hours	1,140.1	(188.2)	28	1,156.8	(86.5)	25	.68	.09

See legend on first page of the table.

Table 9.5 (continued)

Comparison of Contextual Variables for Center-Based Only and Center-Based with Parent Involvement Groups for 1986 Utah Parent Involvement Study

	Center-Based Program			Center-Based + PIE			p^{**} Value	ES*
	x̄	(SD)	n	x̄	(SD)	n		
REASSESSMENT #6								
•Child Health	2.1	(.6)	28	2.2	(.6)	25	.60	.17
•Demographics								
% of children living with mother & father	92.3		26	100.0		23	.18	.25
Annual income	$39,500	($23,004)	26	$38,400	($25,167)	25	.87	-.05
Number of children in home with delays or disabilities	1.1	(.5)	27	1.7	(.9)	25	.01	1.20
•Family Variables								
Family resources (FRS)	118.9	(18.9)	28	120.9	(17.0)	25	.69	.11
Family stress (Holmes-Rahe)	170.8	(82.1)	28	165.4	(119.3)	25	.85	-.07
Family negative events (Holmes-Rahe)	33.8	(48.1)	28	33.0	(41.1)	25	.95	-.02
•Additional Services								
Speech therapy: % receiving 1 hr/month or more	0		28	0		25	1.00	.00
Physical/occupational therapy: % receiving 1 hr/month or more	17.9		28	12.0		25	.56	-.14
Total school hours	1,117.3	(133.4)	28	1,076.2	(133.4)	25	.17	.31
REASSESSMENT #7								
•Child Health	2.7	(.6)	28	2.1	(.6)	25	.96	-1.0
•Demographics								
% of children living with mother & father	85.7		28	96.0		25	.21	.28
Annual income	$32,892	($18,101)	28	$37,087	($21,356)	23	.45	.23
Number of children in home with delays or disabilities	1.1	(.7)	28	1.6	(.8)	25	.02	.71
•Family Variables								
Family resources (FRS)	117.0	(21.9)	28	123.2	(15.4)	25	.25	.28
Family stress (Holmes-Rahe)	156.8	(105.9)	28	164.3	(142.8)	25	.83	.07
Family negative events (Holmes-Rahe)	28.9	(36.0)	28	34.6	(54.5)	25	.65	.16
•Additional Services								
Speech therapy: % receiving 1 hr/month or more	0.0		28	4.0		24	.29	.18
Physical/occupational therapy: % receiving 1 hr/month or more	7.1		28	12.5		24	.32	.24
Total school hours	1,185.3	(44.3)	26	1,156.8	(62.6)	23	.07	-.64
REASSESSMENT #8								
•Child Health	2.1	(.5)	28	2.1	(.5)	25	.93	.00
•Demographics								
% of children living with mother & father	78.6		28	100.0		25	.01	1.06
Annual income	$37,555	($21,303)	27	$36,782	($22,885)	23	.90	-.04
Number of children in home with delays or disabilities	1.2	(.6)	28	1.8	(.9)	25	.01	1
•Family Variables								
Family resources (FRS)	120.9	(19.2)	28	121.2	(14.6)	25	.94	.02
Family stress (Holmes-Rahe)	149.9	(89.2)	28	174.4	(129.0)	25	.42	.27
Family negative events (Holmes-Rahe)	30.9	(41.1)	28	27.6	(41.9)	25	.77	-.08
•Additional Services								
Speech therapy: % receiving 1 hr/month or more	0.0	0	28	0	0	24	.00	.00
Physical/occupational therapy: % receiving 1 hr/month or more	.07	(.26)	28	13.0	.34	24	.52	.23
Total school hours	1,188.6	(56.8)	26	1,118.0	(249.9)	23	.17	-1.24

See legend on first page of the table.

Perceptions concerning family resources was obtained annually via the Family Resource Scale (FRS). (A more complete description of this and other scales used is presented later.) Other stressors which may have affected child or family functioning were measured at reassessment #1 by the Family Inventory of Life Events (FILE) and at reassessments #5, #6, #7, and #8 by the Holmes-Rahe Major Life Events Scale. Scores for the two groups remained very comparable across the reassessments for both family resources and other stresses.

Other intervention obtained by the parent for the child might influence the child's development. At reassessments #1 through #8, parents reported additional services their child received during the previous year. These speech, physical, and occupational therapies were in addition to any that were part of their school program. More than 75% of the families did not report any additional therapies, and only at reassessment #7 did one group receive statistically significantly more additional services than the other group. At this time, the children in the center-based-only group reported spending more hours in school than the children in the center-based with parent involvement group. This data is gathered from retrospective parental reports however, and should be interpreted with caution.

The degree to which the parent is committed to, supportive of, and knowledgeable about the child's intervention program might also influence the child's development. A description of quality of parent involvement was gathered at Reassessment #1 from the intervener who worked most closely with the child's mother. The data obtained was the intervener's rating (low[1], average[2], high[3]) of the parent's attendance, knowledge, and support. The teachers rated the parents in the parent involvement group statistically significantly higher (p = .07) on knowledge, which is what would be expected given the additional instruction parents in this group were receiving. The teachers rated the parents in the two groups similarly on attendance and support. While the mean ratings for these variables tended to be high (2.62 for attendance, 2.40 for knowledge, and 2.42 for support), nearly half the sample were ranked as low or average on one or more of these categories, indicating that interveners were discriminating in the ratings they applied. These intervener ratings of the parents are typical of the situations experienced by many early intervention professionals who work with parents (Lochman & Brown, 1980).

In sum, except for the larger "number of parents in the home" and "other siblings needing special education services" in the center-based with parent involvement group, consistent statistically significant differences of contextual factors between the two groups were not found. Thus, the influence of these contextual factors on the outcome measures of child development and family functioning would appear to be comparable for both the center-based only and the center-based with parent involvement groups.

Cost of Alternate Programs

It is important to determine the cost of adding any type of a parent involvement component to an already established center-based program. Should costs be high and relative benefits low, money used to establish a parent program might be better spent elsewhere. Haskins and Adams (1982) point out that there is a great need for cost analysis in the area of parent education to provide evidence that such programs will justify their costs by increasing the productivity of parents, their children, or both, and/or reduce the necessity for larger investments in treatment programs at some later date. This study has addressed these issues in part, and will provide more conclusive answers as it follows these children through their school years.

The cost of the center-based only program and the center-based with parent involvement program as described above was determined using the ingredients approach advocated by Levin (1983). The ingredients approach is a systematic, well-tested procedure for identifying all of the social costs for implementing alternative programs. It includes costs that are often omitted from cost analysis such as contributed (in-kind) and shared resources. Costs are based on actual expenditures for direct service and administrative personnel, occupancy, equipment, transportation, materials and supplies, miscellaneous, and contributed resources. The cost per child was determined by dividing total resource cost in each category by the number of children receiving services in each program. Table 9.6 shows all costs after they were adjusted for inflation to 1990 dollars.

Direct service and administrative costs included salaries plus benefits for each staff member according to the percentage of FTE allocated to each program. Occupancy charges included the annual rent for the two facilities in which the program was housed, and all utilities, insurance, and maintenance costs. Equipment costs were based on estimates of the market replacement value of all equipment owned by the center, annualized to account for interest and depreciation. In addition, the cost of rental and maintenance of other equipment not owned by the center was determined.

Table 9.6

Cost Per Child for the 1986 Utah Parent Involvement Study (1990 Dollars)

Resources	Center-Based Program (n = 174)	Center-Based + PIE (n = 29)
Agency Resources		
Direct Service	$3,153	$3,334
Administration	608	640
Occupancy	694	694
Equipment	89	89
Transportation		
Children	10	10
Staff	7	7
Materials/Supplies	51	58
Miscellaneous	30	30
SUBTOTAL	**$4,642***	**$4,862***
Contributed Resources		
Volunteer time	25	25
Parent time	416	1,208
Parent Transportation	1,306	1,383
Miscellaneous	2	2
Subtotal	**$1,749**	**$2,618**
Total	**$6,391***	**$7,480***

* *Totals may not add up due to rounding errors.*

Transportation costs were paid by the center for staff home visits, workshop attendance, and errands as well as the costs of bringing low-income children into the center. Transportation costs for all other children were assumed by their parents and are included under "contributed resources." The cost for materials and supplies and miscellaneous included the annual expense to the program for all consumable items and miscellaneous expenses incurred by each program.

Contributed resources included the value of volunteer and parent time. Community members contributed 426 hours during the year to the program. Based on actual attendance data, the average parent in the PIE group spent approximately 13 hours in instructional sessions. Assuming that parents followed PIE curriculum requirements, parents also spent about 67 hours working at home with their child. In addition, parents in both groups provided transportation for their children. The cost of child transportation was estimated based on information provided by parents via telephone interview. All volunteer time in the program was assigned the opportunity cost of $9 per hour. This amount was based on the "median usual weekly earnings for full-time work" plus benefits (U.S. Department of Labor, Bureau of Labor Statistics, 1989). Finally, contributed miscellaneous resources included the market value of a computer donated to the program.

Table 9.6 presents results which demonstrate that the addition of this type of parent involvement is fairly inexpensive. On the average, the addition of parent instruction to the center-based program only costs about $180 more per child in direct costs to the center. This is mostly due to increased personnel costs, although a small amount goes to supplies. However, when the value of contributed resources is added in, this difference is approximately $1,000, reflecting the addition of the parents' time. Although the addition of this type of a parent involvement program is fairly inexpensive in actual dollars for an already-established center-based program, there is a substantial cost to participating parent in terms of their time. The question of the relative effectiveness of the parent involvement will be addressed in the results section.

Data Collection

Data collection included the selection of measures; the recruitment, training, and monitoring of diagnosticians, and the administration of measures at the initial assessment and the subsequent reassessments. The multiple measures used to obtain data on the children and their families and the schedule for the administration of assessments are listed in Table 9.7. Descriptions of the measures are presented in Table 9.8. The battery of assessments selected were those that previous research had suggested would likely be affected by intervention. All of the measures have been used widely in early intervention research, have adequate documentation regarding reliability and validity, and are appropriate for children with disabilities of the ages included in this study. More extensive discussion of the characteristics and psychometric adequacy of these measures is available in White (1986).

Recruitment, training, and monitoring of diagnosticians. With the exception of one BDI tester, this project used the same diagnosticians for the initial assessment, reassessment #1, and reassessment #2. All of the diagnosticians had Master's degrees and extensive experience assessing infants and children with disabilities. In addition, two of the three testers were enrolled in special education doctoral programs. All were trained through a lengthy process which involved approximately 4 hours of independent study, 8 hours of group training, and a minimum of 3 practice administrations. To be certified, a diagnostician had to demonstrate administration and scoring competence to the Institute's assessment coordinator. Once certified, 10% of all administrations were shadow scored for interrater agreement, and all protocols were checked by clerks for adherence to scoring conventions.

At reassessments #3 and #4, new testers were trained. All were graduate

Table 9.7
Schedule of Administration of Measures for Utah 1986 Parent Involvement Study

	Initial Assessment	Reassessment #1	Reassessment #2	Reassessment #3	Reassessment #4	Reassessment #5	Reassessment #6	Reassessment #7	Reassessment #8
CHILD MEASURES									
• Battelle Developmental Inventory	X	X	X	X	X				
• Developmental SPECS					X	X			
• Minnesota Child Development Inventory		X							
• Child Health		X	X		X	X	X	X	X
• Woodcock-Johnson Tests of Achievement, Revised						X	X	X	X
• The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children						X	X	X	X
• Scales of Independent Behavior						X	X	X	X
• Social Skills Rating System (Parent Form)						X	X	X	X
• Social Skills Rating System (Teacher Form)						X	X	X	X
FAMILY MEASURES									
• Parent Stress Index	X	X	X	X	X		X	X	X
• Family Support Scale	X	X	X	X	X	X	X	X	X
• Family Resource Scale	X	X	X	X	X	X	X	X	X
• Family Inventory of Life Events and Changes	X	X							
• Family Adaptation and Cohesion Scale	X	X	X	X	X				
• CES-D Depression Scale		X							
• Child Improvement Questionnaire, Revised		X	X						
• Peabody Picture Vocabulary Test	X*								
• Parent-Child Interaction		X	X		X				
• Public School Teacher Evaluation			X		X	X	X	X	X
• Additional Services		X			X	X	X	X	X
• Parent Self-Awareness Scale						X	X	X	X
• Major Life Events						X	X	X	X
• Comprehensive Evaluation of Family Functioning						X			
• Family APGAR						X	X	X	
• Family Functioning Style Scale							X	X	X
• Dyadic Adjustment Scale								X	

* Given at Reassessment #1, but actually a part of the assessment.

Table 9.8

Description of Tests Administered for Utah 1986 Parent Involvement Study

MEASURES	DESCRIPTION
CHILD MEASURES	
Battelle Developmental Inventory (BDI) (Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984)	A norm-referenced test of developmental functioning completed through child administration and parent interview. Assesses Personal/Social, Adaptive, Motor, Communication, and Cognitive Skills, and provides a total score.
Developmental SPECS (System to Plan Early Childhood Services) (Bagnato & Neisworth, 1990)	Assesses adult perceptions (judgment-based assessment) of child capabilities on 20 developmental dimensions that encompass six domains: Communication, Sensorimotor, Physical, Self-Regulation, Cognition, and Self-Social.
Minnesota Child Development Inventory (MCDI) (Ireton & Thwing, 1974)	Assesses mother's perception of child development in eight areas: General Development, Gross Motor, Fine Motor, Expressive Language, Comprehension-Conceptual, Situation Comprehension, Self Help, and Personal-Social
Child Health (E.I.R.I.)	Assesses the parents evaluation of the child's health during the past year, including general health, illnesses, hospitalization, etc.
Woodcock-Johnson Tests of Achievement--Revised (WJ-R) (Woodcock & Johnson, 1989)	A norm-referenced test of achievement. The test consists of six aspects of scholastic achievement: Letter-Word Identification, Applied Problems, Dictation, Science, Social Studies, and Humanities. Two cumulative scores are provided, a broad knowledge score and a skills knowledge score. Child is the respondent.
The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983)	A pictorial scale of perceived competence and social acceptance for young children. Four domains are assessed: cognitive competence, physical competence, maternal acceptance, and peer acceptance.
Scales of Independent Behavior (SIB) (Bruininks, Woodcock, Weatherman, & Hill, 1985)	The SIB is a norm-referenced test which assesses the functional independence and adaptive behavior of a child. The test is organized into four subdomains: Motor Skills, Social and Communication Skills, Personal Living Skills, and Community Living Skills. Parent is interviewed for information.
Social Skills Rating System (Gresham & Elliot, 1990)	A norm referenced measure of the teacher or parent's estimate of the child's social skills such as: control, assertion, and self-control. Ratings of problem behaviors (externalizing, internalizing, and hyperactivity) and academic competence are also assessed.
FAMILY MEASURES	
Parenting Stress Index (PSI) (Abidin, 1983)	Assesses parent perceptions of stress on the parent-child system. The two main domains are child-related factors and parent factors. The original scale was shortened by Abidin in 1990 to 36 items. The three domains of this short form (PSI/SF) are parent distress, parent-child interaction, and difficult child.
Family Support Scale (FSS) (Dunst, Jenkins, & Trivette, 1984)	Assesses the availability of sources of support as well as the degree to which different sources of support provided are perceived as helpful to families rearing young children.
Family Resource Scale (FRS) (Dunst & Leet, 1985)	Assesses the extent to which different types of resources are perceived as adequate in households with young children. Factors include: General Resources, Time Availability, Physical Resources, and External Support.
Family Inventory of Life Events and Changes (FILE) (McCubbin, Patterson, & Wilson, 1983)	Assesses life events and changes experienced by a family unit during the past 12 months and prior to the past 12 months. The specific areas of potential strain covered by the scale include: Intra-Family, Martial, Pregnancy and Childbearing, Finance and Business, Work-Family Transitions, Illness and Family "Care," Losses, Transitions "In and Out," and Legal.

(continued)

Table 9.8 (continued)

Description of Tests Administered for Utah 1986 Parent Involvement Study

MEASURES	DESCRIPTION
Family Adaptability and Cohesion Evaluation Scale - III (FACES) (Olson, Portner, & Lavee, 1985)	Provides a general picture of family functioning by assessing the family's level of adaptability and cohesion. Family cohesion assesses degree of separation or connection of family members to the family. Adaptability assesses the extent to which the family system is flexible and able to change in various situations.
CES-D Depression Scale (Radloff, 1977)	This scale is a short self-report test designed to measure depression-symptomatology on the general population.
Child Improvement Questionnaire--Revised (Devellis, Revicki, & Bristol, 1985)	The questionnaire has been adapted from the Child Improvement Locus of Control (CILC). The CILC assesses parental perceptions of factors that affect the progress of their child with disabilities. Factors assessed are: chance, efforts by professionals, the child's efforts, parent efforts, and divine intervention.
Peabody Picture Vocabulary Test (PPVT) (Dunn & Dunn, 1981)	Measures the receptive vocabulary of the mother. The score correlates highly with the mother's IQ.
Test of Parent Knowledge (E.I.R.I.)	Assesses parent's knowledge of PIE curriculum. Includes 30 multiple-choice questions.
Parent/Child Interaction (E.I.R.I.)	15 to 20 minute videotape of parent-child interaction following a set protocol devised by EIRI and using specified play materials. A free play period was followed by a clean-up time, joint book reading, parent leaving for 45 seconds, parent returning, and more free-play.
Additional Services (E.I.R.I.)	Provides data on services the child and family have received during the past year outside the study (e.g., Schooling, Early Intervention, Speech Therapy, Physical and Occupational Therapy, Tutoring).
Parent Self-Awareness Scale (PSAS) (Snyder, Weeldreyer, Dunst, & Cooper, 1985)	The PSAS is a 20-item questionnaire that measures the parent's perceived level of personal capabilities, decision-making capabilities, and informational capabilities.
Major Life Events Scale (Holmes & Rahe, 1967)	Assesses parental stress by assigning numerical values to various positive and negative life events occurring within the past year. A separate score of the occurrence of major negative events is also provided.
Comprehensive Evaluation of Family Functioning (CEFF) (McLinden, 1990)	The CEFF examines areas in which a family of a child with special needs may be affected: time demands, acceptance, coping, social relationships, financial demands, well-being, and sibling relationships. It is a parent self-report measure.
Family APGAR (Smilkstein, 1978)	The family APGAR assesses five functional components of family life by presenting five statements to which the parent responds using a Likert-type format. Family functions include: Adaptability, Partnership, Growth, Application, and Resolve.
Family Functioning Style Scale (FFSS) (Deal, Trivette, & Dunst, 1988)	The scale is a 26-item scale that assesses the extent to which the person (i.e. mother) believes that their family is characterized by different strengths and capabilities.
Dyadic Adjustment Scale (DAS) (Spanier 1976)	A 32-item scale that assesses marital satisfaction. Subscales include dyadic consensus, dyadic satisfaction, affectional expression, and dyadic cohesion. Total scores are reported.

students or professionals in special education or language therapy; all were experienced testers; all had worked extensively with children. At Reassessment #5, #6, and #7 all diagnosticians (including those who had been previously certified or those in the process of certifying) attended a workshop reviewing procedures, scoring, etc. in order to recertify.

Although the diagnosticians were aware that research was being conducted, they were "blind" to the specific details, hypotheses, and group membership of participants in the study. Shadow scoring, as outlined above, was conducted on 10% of BDI or WJ-R and SIB administrations. Average interrater reliability scores always exceeded 90%, with the reassessment #6 interrater reliability exceeding 96%. In addition to the shadow scoring, each scored test protocol was reviewed by a clerk. Quality control checklist protocols were prepared and sent to each tester. The checklist included a list of each assessment the tester had administered, and it noted any errors (e.g., basal, ceiling, addition) that were found. No protocols were problematic due to administration or scoring errors.

Initial assessment. The initial assessments took place in late October and early November of 1986. Parents of each child participating in the study completed an informed consent form and were interviewed concerning demographic information. In the first of two assessment sessions, children were administered the Battelle Developmental Inventory (BDI). Testing occurred at the center. In a second assessment session, which usually took place within two weeks of the BDI test session, parents (usually the mother) completed the following family measures: the Parenting Stress Index, Family Support Scale, Family Resource Scale, Family Inventory of Life Events and Changes, and the Family Adaptability and Cohesion Scales. Information pertaining to the reliability and validity of these measures may be found in the first annual report (White & Casto, 1985). Each of these two sessions lasted approximately 1½ hours. Parents were paid a for their participation at this and all subsequent reassessments.

Reassessment #1. The first reassessment was completed 7.5 months later, during the last two weeks of May and the first week of June 1987. The reassessment battery required three test sessions to complete. The reassessment battery consisted of the same battery of tests and surveys as the initial assessment battery as well as some additional measures. For mothers, additional tests and surveys included the CES-D Depression Scale, a survey of child health, the Child Improvement-Questionnaire--Revised (a measure of locus of control), a test of knowledge regarding PIE curriculum, a satisfaction with educational services questionnaire, and the Peabody Picture Vocabulary Test. (Although the PPVT was given at reassessment #1, it was included with the initial assessment measures, reasoning that attending PIE instruction would not affect the scores.) Mothers also completed the Minnesota Child Development Inventory (MCDI), an additional measure of the child's developmental level as perceived by the mother. The reassessment BDI and PPVT were administered by trained diagnosticians. Approximately two months after the intervention sessions were completed a videotape of parent and child was recorded. The interactions lasted approximately 16 to 20 minutes and followed a standardized protocol.

Reassessment #2. A second reassessment was conducted with both treatment groups in June, 1988. No monitoring of parental implementation of training principles took place between the first and second reassessment. Parents were contacted via telephone, and appointments were made for both parents and their child(ren) to complete the core measures. The children were administered the BDI while parents filled out various family measures. In addition to family measures, parents in both treatment groups again completed the questionnaire assessing the parents' satisfaction with the preschool educational services and a test of knowledge regarding PIE curriculum. All parents were interviewed and were given the opportunity to comment on services received at the center. The parents who had received the PIE instruction were asked to discuss their attitudes, knowledge, and satisfaction with the instructional program. They were also asked to discuss how their parenting techniques had changed as a result of the PIE, as well as how they handled stressful parenting. Parent-child interaction was again videotaped.

For those few children (12) who were already in public school, permission was obtained to contact the teachers of study participants. These teachers were asked to complete a questionnaire designed to ascertain the teachers' impressions of the parent's involvement with the child's program and progress in comparison with other parents. This questionnaire also gathered information on the child's classification, school attendance, classroom placement, tests administered, teacher certificates held, and teacher's recommendation for the child's future placement. As an incentive for teachers to participate, two posters appropriate for classroom use were mailed with the questionnaire. This questionnaire had a 100% return rate.

Reassessment #3. A third reassessment was taken during the summer of 1989. Procedures for this reassessment were similar to that of the second reassessment. Parents were contacted via telephone and appointments made for parents and their children to complete the core measures. Assessments were conducted at a local community college and a nearby preschool. The children were administered the BDI while parents completed the Parenting Stress Index, Family Support Scale, Family Resource Scale, Family Adaptability and Cohesion Scales, and a demographic survey. Some of the subjects completed the assessments in their homes. Testing sessions lasted approximately two hours.

Reassessment #4. The procedures for testing at reassessment #4 remained the same. The parents were contacted by letter in January, 1990 informing them of the schedule for testing and encouraging their participation. Permission to contact the school teachers, and the names of the teacher and school were also requested. Most of the testing took place at a special education center in the Salt Lake City area with a few children (primarily those living out of the state) being tested in their homes. Most of the testing was completed in April with some being done in May, June, and July.

Most of the measures were used at previous reassessments. Videotaping of the parents interacting with their child was also completed. The length of the taping was increased to 20 minutes and toys appropriate for older children were included. Each testing sessions lasted approximately 2½ hours.

The public school teachers completed measures of child development, using the Developmental SPECS (System to Plan Early Childhood Services) (Bagnato & Neisworth, 1989). This measure asks the teacher to rate the child's development using Likert-type scales in 19 areas. On these scales a score of 5 signifies that the child's behavior is typical of behavior for children the same age, and a score of 1 signifies severe problems or very atypical development in that area. The teachers also completed a questionnaire describing the children's present educational program and evaluating the parents' participation in the children's education. Teachers were again sent classroom posters to thank them for their participation. At this time, the children were attending 32 different elementary schools. It is highly unlikely their current public school teachers would be aware of the parent involvement component of the intervention program which had transpired over three years before.

Reassessment #5. The procedures for testing at reassessment #5, including the contacting, scheduling, testing location, length of testing, and payment were the same as those at reassessment #4. Most of the testing was completed in April with some being administered in March and May.

Many of the measures were changed for Reassessment #5. The Woodcock-Johnson Test of Achievement--Revised (WJ-R) and the Scale of Independent Behaviors (SIB) replaced the Battelle Developmental Inventory (BDI) due to the age of the children. A measure of child self-concept, the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter & Pike, 1983) was administered to the children. The Pictorial Scale of Perceived Competence and Social Acceptance provides two measures of perceived competence (cognitive and physical) and two measures of perceived social acceptance (from peers and mother). This measure was too difficult for some of the subjects; hence, only 41 subjects completed the measure. A measure of child social skills as perceived by the mother and teacher (Social Skills Rating

System [SSRS]; Gresham & Elliot, 1990) was also used. The parenting stress measures (PSI) and family functioning measure (FACES III) were not used this year. A new measure of family functioning for families of children with special needs (Comprehensive Evaluation of Family Functioning [CEFF]; McLinden, 1990), a measure of general family functioning (Family APGAR; Smilkstein, 1978), a measure of family stress and readjustment (Major Life Events Scale; Holmes & Rahe, 1967), and a measure of parent self-awareness (Parent Self Awareness Scale [PSAS]; Snyder et al., 1985) were also used. The testing session lasted approximately 1½ to 2 hours.

The current school teachers were again asked to complete the Developmental SPECS, a measure of child development, along with the social skills rating scale, and a questionnaire describing the child's present educational program and evaluating the parents' participation in the children's education. Gift certificates to a school supply store were sent to the teachers to thank them.

Reassessment #6. The procedures for this reassessment were the same as those for reassessment #5. Most of the testing was completed at the special education center that was used for reassessments #4 and #5. Some testing was completed in homes in order to accommodate parent schedules or for those living outside of the Salt Lake City area. Most of the testing was completed in March. Fifty-three children and their parents participated in the testing. School teachers were again asked to complete measures. The battery of assessments given was essentially the same as it was at reassessment #5. The Comprehension Evaluation of Family Functioning (CEFF) (McLinden, 1990) and the Developmental SPECS (Bagnato & Neisworth, 1990) were not given. The Parenting Stress Index Short Form (Abidin, 1990) was given to measure parenting stress. A measure of family strengths, the Family Functioning Style Scale (FFSS) (Deal, Trivette, & Dunst, 1988) was added to the battery of assessments. Parents were again paid $50 for their participation and teachers were sent gift certificates redeemable at a school supply store or $10 for their participation.

Reassessment #7. This reassessment was administered like the previous ones, using the same special education center. Some assessments occurred in the children's homes in order to accommodate family needs. Fifty-three children and their families participated during March and April, 1993. School teachers again provided information via mailed questionnaires. The only additional measure was the Dyadic Adjustment Scale (Spanier, 1976) which was a measure of marital satisfaction. Payment for participation remained the same as in previous years.

Reassessment #8. At reassessment #8, families chose between two testing locations, the same special education center or a local community college. Most of the testing occurred during March and April, 1994. Several children who were traditionally tested at home completed the testing in May. Fifty-three children and their families participated again this year. School teachers were asked to complete three questionnaires for which they were paid a total of $20 per child. Some children had more than one teacher, and various questionnaires were completed by each one.

The assessment battery for the families was slightly shorter this year. No new measures were administered, but the family APGAR and the Dyadic Adjustment Scale were dropped. Reimbursement for the families remained the same as previous years.

Results and Discussion

The primary question this study sought to answer was "What are the immediate and long-term effects of adding a parent involvement component to an existing center-based early intervention program on the functioning of participating children and families?" This question was addressed by comparing the two treatment groups, the center-based only group and the center-based with parent involvement group, on child outcome measures and on family functioning measures. In this report, child outcomes will be discussed first, followed by the family functioning outcomes.

The degree to which this question can be answered definitively depends in part on whether the groups were comparable at the initial assessment. This issue is addressed first, followed by the results of the analyses concerning differences between the groups at the various reassessments.

Comparability of Groups on Initial Assessment Measures

As was noted in the section on demographic characteristics, the two groups were very comparable on family demographic characteristics (refer to Table 9.1); the groups were different only on the number of children living with both parents and the number of families having other children with disabilities.

The two groups were also comparable on the initial assessment measures. As can be seen in Table 9.9, there were no statistically significant differences on any of the child development or family measures. The children had an average computed developmental quotient of 58, which would be considered moderately delayed. As a group, the parents were experiencing significant child-related stress (measured by the PSI) with the mean child-related stress ranking at the 88th percentile (compared to PSI norms). The parents also reported a fair number of disrupting events in comparison to the national norms.

Selection of Covariates

The majority of analyses presented in this section are based on analysis of covariance procedures completed using SPSS-PC and SPSS for Windows 6.0. (Analyses other than analyses of covariance are described as such in the text and/or table.) Treatment group served as the independent variable, and dependent variables were scores obtained from the assessment instruments described earlier. Even though subjects were randomly assigned to groups, analysis of covariance procedures were useful for two purposes: (a) to increase the statistical power of a study by reducing error variance; and (b) to adjust for any pretreatment differences which were present between the groups. In either application, the degree to which analysis of covariance was useful depended on the correlation between the covariate(s) selected and the outcome variable for which analyses were being done. However, since one degree of freedom was lost for each covariate used, a limited number of covariates were used in any given analysis.

Table 9.9
Comparison on Initial Assessment Measures of Center-Based and Parent Involvement Groups in the 1986 Utah Parent Involvement Study

	Center-Based Program				Center-Based + PIE					
	$\bar{x}$	(SD)	%ile	n	$\bar{x}$	(SD)	%ile	n	p Value	ES
•Battelle Developmental Inventory (BDI)[·]										
Personal Social	85.6	(27.7)		28	85.3	(30.6)		28	.97	-.01
Adaptive Behavior	54.0	(14.2)		28	55.9	(16.5)		28	.64	.13
Motor	69.8	(22.7)		28	75.4	(24.4)		28	.38	.25
Communication	37.8	(13.7)		28	39.4	(15.3)		28	.68	.12
Cognitive	30.0	(8.9)		28	31.8	(12.7)		28	.55	.20
TOTAL	277.2	(73.1)		28	287.8	(85.7)		28	.62	.15
•Parenting Stress Index[♦] **(PSI) Percentile Rank**										
Child Related Domain (range 47 to 235)	122.7	(23.5)	90	28	117.3	(17.7)	86	27	.34	.23
Other Related Domain (range 54 to 270)	131.7	(30.5)	70	28	137.6	(20.1)	76	27	.40	-.19
•Family Adaptation and Cohesion Evaluation Scales (FACES)										
Adaptability (range 0 to 50)	24.5	(5.8)		28	25.7	(6.0)		28	.46	.21
Cohesion (range 0 to 50)	37.9	(8.1)		28	39.4	(4.5)		28	.38	.19
•Family Resource Scale (FRS)[']	114.5	(18.2)	42	28	112.9	(18.0)	40	27	.74	-.09
•Family Support Scale (FSS)[']	28.5	(11.4)	52	26	29.2	(10.2)	59	26	.80	.06
•Family Index of Life Events[♦] **(FILE)**	11.4	(6.8)	31	28	12.5	(6.9)	30	27	.56	-.16

[·] Statistical analyses for the BDI were conducted using raw scores and these are presented in the table.

['] Analyses for the FSS and FRS are based on raw scores indicating number of supports on resources indicated by the family as being available. Higher scores and positive ESs are considered better. No norming sample is reported for these measures. To assist with interpretation, a percentile score is reported in the table based on all assessments collected as a part of the Longitudinal Studies (currently, 645 families with handicapped children).

[♦] Analysis for PSI & FILE are based on raw scores. Lower scores represent less stress and are considered better. Both scales provide norms. High percentiles on the PSI represent more stress, high percentiles on the FILE represent fewer stressful events.

$$ES = \frac{(\text{Center-Based + PIE Adj}\,\bar{x}) - (\text{Center-based Adj}\,\bar{x})}{\text{Center-Based SD}}$$

Positive effect sizes indicate an advantage for the children in the parent involvement group.

All pretest assessment and demographic variables were considered as potential covariates. The final selection of covariates depended on a judgment of which variable or set of variables could be used to maximize the correlation or multiple correlation with the outcome variable in question and still include those demographic or assessment variables for which there were the largest pretreatment differences. For each analysis, the specific covariates used are indicated in the table.

Although sample sizes for this study were as large or larger than previous early intervention studies with these types of children, the statistical power of the analysis was still a concern. By setting the alpha level for all tests of statistical significance at $p \leq .10$, and by using analysis of covariance procedures, the statistical power of the analyses was substantially increased. According to Hopkins (1973) and Cohen (1977), in those cases where a covariate or set of covariates could be found which correlated at least .60 with the dependent variable in question (which was almost always the case in these analyses), and with alpha set at $p \leq .10$, the statistical power was approximately 81% for finding moderately sized differences (defined by Cohen as differences of a half a standard deviation).

Effects of Alternative Forms of Intervention on Measures of Child Functioning

Reassessment #1 group comparisons. The results of the BDI and the Minnesota Child Development Inventory (MCDI) at reassessment #1 (approximately two months after the PIE instruction was completed) demonstrate that the two groups were developmentally very comparable. Only one statistically significant difference was found out of 14 scores (refer to Table 9.10). On the personal-social domain of the BDI, the children in the center-based with parent involvement group scored higher than the children in the center-based only group. Other than this one difference

Table 9.10

Comparison of Reassessment Measures of Child Functioning for Subjects in Center-Based Only and Center-Based with Parent Involvement Groups (Reassessments #1-#8) in the 1986 Utah Parent Involvement Study

Variable	Covariates*	Center-based only $\bar{x}$	Center-based only (SD)	Center-based only Adj.$\bar{x}$*	Center-based only n	Center-based + PIE $\bar{x}$	Center-based + PIE (SD)	Center-based + PIE Adj.$\bar{x}$*	Center-based + PIE n	ANCOVA F	p Value	ES
REASSESSMENT #1												
• **Age in months at Reassessment #1***		50.0	(10.5)		28	48.6	(10.6)		28	.24	.62	-.13
• **Battelle Developmental Inventory (BDI) Raw Scores for:**												
Personal-Social	1,5,7	87.3	(28.0)	88.4	28	98.5	(29.8)	97.4	28	4.09	.05	.32
Adaptive Behavior	2,3,7	56.7	(15.4)	58.1	28	61.6	(17.2)	60.2	28	.89	.35	.14
Motor	3,7	77.4	(23.9)	80.7	28	83.1	(28.5)	79.8	28	.15	.70	-.04
Communication	4,5,7	44.0	(16.4)	45.7	28	46.0	(19.6)	44.3	27	.52	.47	-.09
Cognitive	4,5,7	34.3	(13.7)	35.4	28	38.3	(15.8)	37.2	28	.78	.38	.13
Total	6,7	298.9	(81.6)	306.6	28	327.3	(92.3)	319.7	28	2.27	.14	.16
• **MCDI**												
General Development	6	76.0	(22.9)	77.4	28	78.8	(23.9)	77.4	28	.00	.99	.00
Gross Motor	3	21.6	(6.4)	22.3	28	22.3	(7.2)	21.6	28	.41	.52	-.11
Fine Motor	2, 3	29.9	(6.4)	30.4	28	30.4	(6.7)	29.9	28	.15	.70	-.08
Expressive Language	4	36.9	(10.7)	37.4	28	37.0	(11.4)	36.5	28	.27	.60	.08
Comprehension Conceptual	5	29.8	(13.3)	30.7	28	32.0	(15.0)	31.0	28	.02	.90	.02
Situation Conceptual	6	27.6	(7.4)	28.0	28	27.5	(8.7)	27.1	28	.40	.53	-.12
Self-Help	2	20.8	(7.3)	21.2	28	22.1	(7.2)	21.7	28	.22	.64	.07
Personal-Social	1	22.4	(5.8)	22.4	28	23.5	(6.2)	23.5	28	1.15	.29	.19
REASSESSMENT #2												
• **Age in months at Reassessment #2***		61.4	(11.9)		20	60.6	(11.6)		20	.05	.83	-.07
• **Battelle Developmental Inventory (BDI) Raw Scores for:**												
Personal-Social	4,5,7	101.7	(23.9)	103.9	20	111.4	(19.1)	109.2	20	1.58	.22	.22
Adaptive Behavior	2,3,7	67.4	(15.7)	69.0	20	72.6	(12.1)	71.0	20	.46	.50	.13
Motor	3,7	92.4	(20.5)	95.9	20	102.5	(24.3)	99.0	20	.85	.36	.15
Communication	4,5,7	50.4	(17.7)	52.3	20	56.1	(17.1)	54.1	20	.26	.61	.10
Cognitive	4,5,7	41.4	(16.2)	43.5	20	51.0	(18.0)	48.9	20	2.78	.10	.33
Total	6,7	353.2	(76.5)	362.1	20	394.5	(72.5)	385.5	20	4.08	.05	.31
REASSESSMENT #3												
• **Age in months at Reassessment #3***		74.1	(9.6)		26	72.6	(11.2)		25	.25	.62	-.16
• **Battelle Developmental Inventory (BDI) Raw Scores for:**												
Personal-Social	1,5	113.8	(34.7)	115.6	26	128.3	(23.3)	126.5	25	2.82	.10	.31
Adaptive Behavior	2,3	73.3	(17.8)	76.1	26	83.4	(15.2)	80.6	25	1.85	.18	.25
Motor	3	93.2	(28.1)	98.9	26	107.6	(27.5)	101.9	25	.57	.45	.11
Communication	4,5	56.9	(22.6)	58.9	26	64.6	(21.6)	62.6	25	.68	.41	.16
Cognitive	4,5	45.2	(17.2)	47.3	26	59.4	(22.7)	57.4	25	6.35	.02	.59
Total	6	382.4	(99.1)	393.7	26	443.0	(92.0)	431.7	25	3.87	.06	.38

(continued)

* Covariance adjusted means

* Results computed among t-tests. Means are not adjusted. T-test scores (not ANCOVA F) are given.

* Covariates included BDI pretest scores (1 = Personal-Social, 2 = Adaptive Behavior, 3 = Motor, 4 = Communication, 5 = Cognitive, 6 = Total) and other pretest variables (7 = Child's Age, 8 = Number of Siblings in the Home)

$$ES = \frac{(\text{Center-Based + PIE Adj}.\bar{x}) - (\text{Center-based Adj}.\bar{x})}{\text{Center-Based SD}}$$

Positive effect sizes indicate an advantage for the children in the parent involvement group.

• Each SPECS score includes a different number of items, each of which are ranked by the teacher on a Likert-type scale of 1 to 5. A score of 5 represents development in that area that is typical of peers and a score of 1 represents development that is atypical or problematic. Therefore, the optimal developmental score for communication is 10; sensorimotor, 20; physical, 15; self-regulation, 20; cognition, 10; self-social, 20.

• The WJ-R provides broad knowledge and skills knowledge raw achievement scores to measure child developmental outcomes. Higher scores indicate greater achievement.

• The SIB measures, from parent report, the child's degree of independence in the social/communication, personal living, and community living domains. High scores represent higher degrees of independent behaviors.

Scores in this category represent percentages related to child's present educational placement. The questions for Reassessments #4 and #5 differed slightly from those used at Reassessment #6 or #7.

These scales provide the parent and teacher's perception of the child's social skills and their problems. Higher scores represent more, either more skills or more problems.

• Scales provide child's perception of these 4 categories of self-competence. Higher scores are interpreted as better.

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Table 9.10 (continued)

Comparison of Reassessment Measures of Child Functioning for Subjects in Center-Based Only and Center-Based with Parent Involvement Groups (Reassessments #1 - #8) in the 1986 Utah Parent Involvement Study

		Center-based only				Center-based + PIE						
Variable	Covariates[1]	$\bar{x}$	(SD)	Adj. $\bar{x}$[*]	n	$\bar{x}$	(SD)	Adj. $\bar{x}$[*]	n	ANCOVA F	p Value	ES
REASSESSMENT #4												
• **Child Age at Reassessment #4**[*]		84.3	(10.9)		28	83.0	(11.6)		24	.19	.67	-.12
• **Battelle Developmental Inventory (BDI) Raw Scores for:**												
Personal-Social	1,4	128.8	(33.9)	129.2	28	144.1	(22.8)	143.7	24	5.13	.03	.43
Adaptive Behavior	2,3	79.1	(21.6)	81.3	28	89.8	(17.5)	87.7	24	2.31	.14	.30
Motor	3	101.4	(31.8)	106.1	28	116.3	(32.9)	111.6	24	1.28	.26	.17
Communication	4,5	64.4	(23.9)	66.8	28	75.0	(24.5)	72.5	24	1.70	.20	.24
Cognitive	4,5	59.8	(26.3)	62.3	28	72.1	(25.8)	69.6	24	2.03	.16	.28
Total	6	433.5	(114.6)	443.2	28	497.3	(105.5)	487.7	24	4.11	.05	.39
• **Teacher's Developmental**[*] **SPECS**												
Communication	4	6.8	(1.7)	6.9	25	6.4	(1.9)	6.3	22	1.47	.23	-.35
Sensorimotor	3	14.0	(3.7)	14.3	25	14.8	(3.0)	14.5	22	.07	.80	.05
Physical		11.6	(1.7)	11.6	25	12.2	(1.7)	12.2	22	1.36	.25	.35
Self-Regulation	6	13.8	(3.6)	13.9	25	16.0	(3.3)	15.9	22	4.27	.05	.56
Cognition	5	5.6	(2.3)	5.7	25	6.3	(2.3)	6.1	22	.52	.49	.17
Self/Social	6	12.7	(3.7)	12.8	25	14.6	(3.2)	14.5	22	3.02	.09	.46
• **School Placement**[*]												
% not eligible for special education		4.0			25	13.6			22		.27	.48
% time in typical classroom		26.3			26	37.3			21	1.00	.32	.29
% time in full-time special education		73.1			26	56.8			21	1.90	.18	.40
REASSESSMENT #5												
• **Age in months at Reassessment #5**[*]		98.0	(10.5)		28	96.6	(11.2)		25	.22	.64	-.13
• **Woodcock-Johnson Revised Achievement Raw Scores for:**[*]												
Broad Knowledge Total	5	441.2	(29.7)	443.5	28	456.9	(24.8)	454.4	24	2.69	.11	.37
Skills Knowledge Total	5	384.3	(54.3)	388.4	28	416.7	(48.0)	412.2	24	3.55	.07	.44
• **Scales of Independent Behavior** (SIB)[*]												
Motor Skills	3	435.5	(38.3)	440.2	28	448.2	(33.1)	443.6	24	.25	.62	.09
Social/Communication Skills	6	454.2	(25.0)	455.9	28	465.5	(22.0)	463.7	24	2.14	.15	.31
Personal Living Skills	3	454.8	(26.8)	457.8	28	463.1	(20.3)	460.1	24	.24	.63	.09
Community Living Skills	5	430.2	(28.3)	432.4	28	445.5	(26.6)	443.3	24	3.11	.08	.39
Total	3,5	443.7	(24.1)	446.6	28	455.7	(22.0)	452.8	24	1.63	.21	.26
• **Teacher Developmental SPECS**[*]												
Communication	4	6.5	(1.4)	6.5	28	7.0	(1.8)	7.0	25	1.08	.30	.36
Sensorimotor	3	15.0	(2.6)	15.2	28	16.0	(2.6)	15.8	25	.63	.43	.23
Physical		11.3	(2.2)	11.3	28	12.2	(1.9)	12.2	25	2.59	.11	.41
Self-Regulation	6	13.7	(3.4)	13.8	28	14.8	(3.4)	14.7	25	.91	.35	.26
Cognition	5	5.4	(2.2)	5.5	28	6.1	(2.5)	6.0	25	.47	.50	.23
Self-Social	6	12.9	(3.5)	13.1	28	13.8	(3.7)	13.7	25	.42	.52	.17
• **Social Skills (SSRS)**												
Parent Evaluation of Social Skills	1	85.6	(21.6)	85.9	28	87.7	(19.1)	87.5	24	.11	.75	.07
Parent evaluation of problem behaviors		104.6	(15.9)		28	104.3	(15.4)		24	.01	.93	.02
Teacher evaluation of Social Skills	1	86.7	(15.7)	86.9	28	88.0	(17.5)	87.8	25	.04	.84	.06
Teacher Evaluation of Problem behaviors		110.3	(14.0)		28	105.3	(11.5)		25	1.95	.17	.36
• **Perceived Competence and Social Acceptance**[*]												
Cognitive Competence	5	20.8	(2.6)	20.8	21	20.1	(2.8)	20.1	21	.95	.34	-.27
Physical Competence	3,8	16.4	(5.4)	17.2	21	18.1	(4.0)	17.3	21	.00	.96	.02
Social Acceptance by Peers		17.3	(4.2)		21	17.7	(4.5)		21	.10	.75	.10
Social Acceptance by Mother		18.4	(3.8)		21	18.0	(3.8)		21	.16	.69	-.11
• **School Placement**												
% not eligible for special education	6	10.7		11.4	28	12.0		11.3	25	.00	.99	-.07
% in typical classroom	6	21.4		22.6	28	36.0		34.8	25	.96	.33	.40
% in full-time special classroom	6	64.3		62.5	28	48.0		49.8	25	.88	.35	.38

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Table 9.10 (continued)

Comparison of Reassessment Measures of Child Functioning for Subjects in Center-Based and Parent Involvement Groups (Reassessments #1 - #8) in the Utah Parent Involvement Study

		Center-based only				Center-based + PIE						
Variable	Covariates	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	$\bar{x}$	(SD)	Adj. $\bar{x}$	n	ANCOVA F	p Value	ES
REASSESSMENT #6												
• **Age in months at Reassessment #6**		110.0	(10.5)		28	108.6	(11.2)		25	.22	.64	-.13
• **Woodcock-Johnson Revised Achievement Raw Scores for:**												
Broad Knowledge Total	5	450.8	(31.8)	453.3	28	464.8	(24.9)	462.0	24	1.61	.21	.27
Skills Knowledge Total	5	398.4	(54.0)	402.9	28	430.9	(53.0)	426.1	24	3.22	.08	.43
• **Scales of Independent Behavior** (SIB)												
Motor Skills	3	440.0	(37.8)	445.0	28	449.4	(34.7)	444.3	25	.01	.91	-.02
Social/Communication Skills	6	457.6	(25.9)	459.3	28	466.8	(21.0)	465.1	25	1.05	.31	.22
Personal Living Skills	3	458.1	(27.6)	461.2	28	467.5	(17.9)	464.4	25	.46	.50	.12
Community Living Skills	5	435.3	(28.4)	437.5	28	449.5	(23.4)	449.5	25	2.70	.11	.42
Total	5,6	447.9	(24.3)	450.8	28	458.4	(21.2)	455.5	25	.90	.35	.19
• **Social Skills (SSRS)**												
Parent Evaluation of Social Skills	1	88.1	(25.4)	88.4	28	91.6	(19.5)	91.3	25	.27	.60	.11
Parent evaluation of problem behaviors		108.5	(12.0)		28	100.1	(18.4)		25	3.96	.05	.70
Teacher evaluation of Social Skills	1	88.6	(14.7)	88.8	28	92.9	(16.2)	92.7	24	.97	.33	.27
Teacher Evaluation of Problem behaviors		108.5	(18.3)		28	101.0	(12.0)		24	2.94	.09	.41
• **Perceived Competence and Social Acceptance**												
Cognitive Competence	5	18.7	(3.5)	18.8	23	20.5	(2.9)	20.4	21	2.84	.10	.46
Physical Competence	3,8	16.9	(5.2)	17.4	23	19.2	(3.9)	18.7	21	1.07	.31	.25
Social Acceptance by Peers		17.2	(3.5)		23	18.6	(5.3)		21	1.08	.30	.40
Social Acceptance by Mother		16.7	(3.9)		23	16.1	(4.3)		21	.17	.69	-.15
• **School Placement**												
% not eligible for special education	6	7.1		7.5	28	12.5		12.1	24	.30	.59	.26
% in typical classroom	6	19.2		21.1	26	38.1		36.2	21	1.66	.20	.52
% in full-time special classroom	6	80.8		78.9	26	61.9		63.8	21	1.29	.26	.52
REASSESSMENT #7												
• **Age in months at Reassessment #7**		122.0	(10.5)		28	120.6	(11.2)		25	.22	.64	-.13
• **Woodcock-Johnson Revised Achievement Raw Scores for:**												
Broad Knowledge Total	5	457.3	(32.1)	459.8	28	469.1	(27.1)	466.6	24	.86	.36	.21
Skills Knowledge Total	5	407.5	(60.7)	412.3	28	439.9	(51.2)	435.1	24	2.74	.10	.38
• **Scales of Independent Behavior** (SIB)												
Motor Skills	3	445.0	(36.9)	450.3	28	452.0	(40.7)	446.7	25	.24	.63	-.10
Social/Communication Skills	6	462.0	(27.1)	463.8	28	470.5	(20.7)	468.8	25	.74	.39	.18
Personal Living Skills	3	463.5	(28.2)	466.5	28	470.9	(22.1)	468.0	25	.07	.79	.05
Community Living Skills	5	445.5	(30.4)	447.4	28	455.4	(25.9)	453.5	25	.75	.39	.20
Total	5,6	454.1	(25.4)	455.7	28	462.3	(24.6)	460.6	25	.64	.43	.19
• **Social Skills (SSRS)**												
Parent Evaluation of Social Skills	1	91.9	(23.9)	92.1	28	91.1	(20.8)	90.8	25	.06	.81	-.05
Parent evaluation of problem behaviors		107.8	(16.3)		28	103.9	(13.0)		25	.91	.34	.24
Teacher evaluation of Social Skills	1	87.1	(13.3)	87.3	28	97.7	(16.4)	97.5	22	6.23	.02	.77
Teacher Evaluation of Problem behaviors		111.0	(12.4)		28	104.2	(13.7)		22	3.35	.07	.55
• **Perceived Competence and Social Acceptance**												
Cognitive Competence	5	19.0	(4.1)	19.1	25	20.8	(3.0)	20.6	20	1.85	.18	.37
Physical Competence	3,8	16.3	(5.2)	16.9	25	18.7	(4.0)	18.0	20	.81	.37	.21
Social Acceptance by Peers		18.0	(3.2)		25	18.4	(5.0)		20	.06	.80	.13
Social Acceptance by Mother		16.9	(2.8)		25	16.7	(4.3)		20	.04	.84	-.07
• **School Placement**												
% not eligible for special education	6	0.0		0.0	28	4.3		4.6	23	1.43	.24	.43
% in typical classroom	6	39.3		40.1	28	43.5		42.7	23	.03	.86	.10
% in full-time special classroom	6	60.7		59.9	28	56.5		57.3	23	.03	.86	.10

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Table 9.10 (continued)

Comparison of Reassessment Measures of Child Functioning for Subjects in Center-Based and Parent Involvement Groups (Reassessments #1 - #8) in the Utah Parent Involvement Study

		Center-based only				Center-based + PIE						
Variable	Covariates[1]	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	ANCOVA F	p Value	ES
REASSESSMENT #8												
• **Age in months at Reassessment #8**		131.8	(10.8)		28	130.5	(11.0)		25	.19	.66	-.12
• **Woodcock-Johnson Revised Achievement Raw Scores for:**												
Broad Knowledge Total	5	458.5	(33.7)	461.0	28	476.3	(24.3)	473.7	24	3.11	.08	.38
Skills Knowledge Total	5	410.2	(61.5)	415.2	28	445.9	(53.6)	441.0	24	3.36	.07	.42
• **Scales of Independent Behavior** (SIB)												
Motor Skills	3	443.3	(43.0)	449.0	28	459.9	(36.1)	454.2	25	.54	.47	.12
Social/Communication Skills	6	463.6	(26.0)	467.2	28	477.4	(20.5)	477.4	25	2.24	.14	.39
Personal Living Skills	3	462.3	(26.6)	465.2	28	479.3	(20.3)	476.4	25	4.86	.03	.42
Community Living Skills	5	445.5	(26.9)	447.5	28	462.6	(25.5)	460.5	25	4.44	.04	.48
Total	5,6	454.3	(25.6)	455.8	28	469.8	(21.9)	468.2	25	4.40	.04	.48
• **Social Skills (SSRS)**												
Parent Evaluation of Social Skills	1	90.6	(23.7)	90.6	27	97.2	(20.6)	97.2	25	1.37	.25	.28
Parent evaluation of problem behaviors		108.0	(13.4)		27	102.0	(13.9)		25	2.44	.13	.45
Teacher evaluation of Social Skills	1	88.3	(16.2)	88.7	27	97.3	(10.2)	96.9	21	4.28	04	.51
Teacher Evaluation of Problem behaviors		110.9	(11.2)		27	104.1	(10.3)		21	4.64	.04	.61
• **Perceived Competence and Social Acceptance**												
Cognitive Competence	5	18.7	(4.0)	18.8	23	20.4	(3.0)	20.4	23	2.30	.14	.40
Physical Competence	3,8	16.9	(5.6)	17.5	23	19.1	(4.2)	18.5	23	.55	.46	.18
Social Acceptance by Peers		17.7	(4.1)		23	19.3	(3.8)		23	2.04	.16	.39
Social Acceptance by Mother		16.4	(4.1)		23	17.4	(4.4)		23	.64	.43	.24
• **School Placement**												
% not eligible for special education	6	3.8		3.6	26	4.8		5.0	21	.05	.82	.11
% in typical classroom	6	65.4		67.0	26	76.2		74.6	21	.30	.59	.27
% in full-time special classroom	6	34.6		33.0	26	23.8		25.4	21	.30	.59	.27

See first page of table for legend.

(which may have been a chance occurrence), there was no definitive developmental advantage for either group.

Reassessment #2, #3, and #4 group comparison. The findings for reassessments #2, #3, and #4 were somewhat different than were the reassessment #1 findings. At reassessments #2, #3, and #4, the children in the center-based with parent involvement group performed statistically significantly better on the total BDI than the children in the center-based only group (see Table 9.10). They also scored statistically significantly higher on the BDI domains of personal-social development at reassessments #3 and #4, and cognitive development at reassessments #2 and #3. The effect sizes of these differences also increased from reassessment to reassessment.

Other measures taken at reassessment #4 supported the BDI differences between the groups for this reassessment. The teachers evaluated the children's development in six areas, communication, sensorimotor, physical, self-regulation, cognition, and self/social using the Developmental SPECS (Bagnato & Neisworth, 1989). The children in the parent involvement group did statistically significantly better than the children in the center-based group on two of the six scales (i.e., self-regulation and self/social subscales).

Information allowing the investigation of the effect of parent instruction on later school placement was provided by teacher questionnaires at reassessments #2 and #4. At reassessment #2, only 12 of the 56 children were in school, but by reassessment #4, the youngest child in the sample was over five years of age. At this time, 50 of the 52 children tested were in some type of public school (preschool to second grade), one was in a private preschool program, and one in a home-based program. More children in the center-based only group were eligible for special education services (96% compared to 86.4% for the center-based with parent involvement group). Likewise, more children in the center-based only group attended special education classes; conversely, more children in the center-based with parent involvement group attended typical classes (see Table 9.10). Although these statistics favored the children in the center-based with parent involvement group, the differences between groups were not statistically significant. The effect sizes ranged from .29 to .48.

Reassessment #5, through #8 comparisons. At reassessments #5, #6, #7, and #8 a number of different measures were used to assess child development. The Woodcock-Johnson Tests of Achievement (WJ-R) and the Scales of Independent Behavior (SIB) replaced the Battelle Developmental Inventory (BDI). Measures of the child's social skills and the child's perceptions of their own competencies and acceptance were added. (Some children were not able to complete the measure of self-competence at the earlier reassessments because they did not understand the questions.) Generally, at each reassessment child performance was comparable between the two groups, although the children in the center-based with parent involvement group usually scored higher on measures of development/achievement social skills, self competence, and school placement than the children in the center-based only group (refer to Table 9.10). The findings on these measures are discussed in that order.

The Woodcock-Johnson Achievement Test--Revised provides two domain scores, a broad knowledge score and a skills knowledge score. The broad knowledge domain includes science, social studies, and humanities subscales; and the skills knowledge domain includes letter-word identification, applied problems, and dictation subscales. The Scales of Independent Behavior provided four subscale scores and a total score. The Motor Scale includes gross and fine motor skills. The Social/ Communications Scale includes social interaction, language comprehension, and language expression scores. The Personal Living Scale includes catering and meal preparation, toileting, dressing, self-care, and domestic skills. The Community Living Scale includes time and punctuality skills, money and value skills, work skills, and home-community orientation skills.

No statistically significant differences between the two groups were found on the Broad Knowledge domain of the WJ-R at reassessments #5, #6, or #7, although the p value at reassessment #5 indicated a trend in favor of the center-based parent involvement group. Even at reassessments #6 and #7, the center-based parent involvement group mean scores were higher than the center-based only group. At reassessment #8, the adjusted mean scores were statistically significantly different between the two groups. The trend manifest since reassessment #5 continued with the center-based parent involvement group scoring significantly higher. The average effect across the four reassessments reached .31. There was also a statistically significant advantage for the center-based with parent involvement on the Skills Knowledge domain (p = .07, .08, .10, and .07 for reassessments #5, #6, #7, and #8 respectively). The average effect size across the reassessments was .44 or almost one-half of a standard deviation. At reassessment #8, the effect size was .50. On the measure of independent behaviors and skills (SIB), the two groups were comparable across reassessments #5, #6, and #7 except for the Community Living subscale. The children in the center-based with parent involvement group scored statistically significantly higher on the Community Living Scale subscale of the SIB at reassessment #5 and #8 and nearly so at Reassessment #6 (p = .11). The respective effect sizes were .39, .42, and .48. The SIB at reassessment #8 was unusually significant on the Personal Living and Community Living subscales and the Total Score. Each score approached a half a standard deviation for an effect size in favor of the center-based parent involvement group. The findings on the other measure of child development, the Developmental SPECS completed by the teachers at reassessment #5 showed no differences between the groups.

Parents and teachers rated the children's social skills (SSRS). Two scores, social skills and problem behaviors are reported for each reassessment. No group differences were found at reassessment #5 on any of the parent or teacher ratings. However, at reassessment #6, parents and teachers reported that the children in the center-based only group had a statistically significant amount more problem behaviors than the center-based with parent involvement group. Teachers again reported that the center-based only group had more problem behaviors at reassessments #7 and #8. They also reported that the center-based with parent involvement group demonstrated more socially appropriate scores at both reassessments. The effect sizes for those group comparisons where statistically significant differences were found were generally half a standard deviation or greater. However, parents did not perceive the social skills and problem behaviors of the two groups to be different at either reassessment.

Four dimensions of perceived competence and acceptance were measured: cognitive competence, physical competence, peer acceptance, and maternal acceptance. One statistically significant difference was found at reassessment #6. The children in the center-based with parent involvement group perceived themselves as being more cognitively competent than did the center-based group of children. No group differences in perceptions of competence or acceptance were found at reassessment #5, #7. or #8.

Information concerning school placement was provided by the teachers at reassessments #5, #6, #7, and #8. At reassessment #7, 51 of the 53 children were in public schools, one was in a private school, and one was in a home school. The children were in grades two through five. Across reassessments #4 through #8, more of the children in the center-based only group were eligible for special education, fewer were in typical classrooms, and more were in special education classrooms than were the children in the center-based with parent involvement group, but the differences between the groups were not statistically significant.

In sum, some advantage in development was found on the BDI scores across reassessments for the children in the center-based with parent involvement. The statistically significant difference in personal-social development at reassessment #1 might have been a chance finding, but with the difference being statistically significant at reassessments #3 and #4, it suggests the intervention had an impact. Similarly, there was a consistent statistically significant advantage on the BDI cognitive domain at reassessments #2 and #3, and the total BDI score at reassessments #2, #3, and #4 favoring the children in the center-based with parent involvement group. Again, the consistency of scores appear to indicate an impact of the intervention. Similarly, the advantage on the Skills Knowledge score by the center-based with parent involvement group was maintained across reassessments #5 to #8.

Another consistent statistically significant finding was provided by different teachers from reassessments #6 through #8. Teachers consistently rated children in the center-based only group as displaying more problem behaviors. The trend was apparent at reassessment #5, though it was not statistically significant. Teachers further rated the center-based with parent involvement group children as displaying statistically significantly more social skills at reassessment #7 and #8 (<.05 ES = .77 and .51 respectively).

A few other differences between groups were intermittently statistically significant. These may be attributed to chance. However, all the statistically significant differences (e.g., SPECS self-regulation and self-social scores at reassessment #4, SIB community living scale at reassessment #5, SSRS problem behavior scores by parents at reassessment #6, social skills and the majority of the SIB scores at reassessment #8) favored the children in the center-based with parent involvement group. None of the statistically significant findings favored the children in the center-based only group.

When the difference between groups was not statistically significant, the difference in scores was attributed to error measurement. However, when a vast majority of the comparisons (104 of 127) favor the center-based with parent involvement group, the finding of some developmental advantage for this group appears to be substantiated.

Effects of Alternative Forms of Intervention on Family Functioning

The research question addressed in this part of the analyses was whether adding a parent instruction component to an early intervention program resulted in changes to parents' perceptions of social support, parenting stress or family functioning. Changes in family functioning were assessed annually by a number of family measures. These functions included: parenting stress (PSI), family adaptability and cohesion (FACES III), and family support (FSS). These were measured at reassessments #1 to #4. In addition, reassessments #1 and #2 included the Child Improvement Questionnaire which measured the parents' perception of the factors that influence or control the progress of the child. At reassessment #5, the Comprehensive Evaluation of Family Functioning (CEFF) assessed functioning in areas of family life that may be impacted by having a child with special needs. The Parent Self-Awareness Scale was added to measure the parent's perceived level of capabilities, and the Family APGAR was used as a general measure of family functioning/coping. At reassessments #6 - #8, the short form (36 item) of the Parenting Stress Index (PSI/SF) was reintroduced to measure parenting stress. The domain scores reported are parenting distress, parent-child dysfunctional interaction, and difficult child. The Family Functioning Style Scale was added to measure family strengths. The Dyadic Adjustment Scale (DAS) was administered at reassessment #7 to assess marital satisfaction.

Results of the analysis of measures of family functioning for the eight reassessments are shown in Table 9.11. The findings are discussed under the headings of family social support, parenting stress, family functioning, parent responsibility and effectiveness, and parent involvement in child's education.

Family social support. The difference in reported social support was significantly different at reassessment #1 just after the parents had attended the classes (p = .08, ES = .42). The families in center-based with parent involvement group reported more social support than did the families in the center-based only group. This finding was not replicated across the subsequent reassessments. However, the scores were very similar over the years, only differing less than seven points from reassessments #2 through #8.

Parenting stress. Parenting stress was measured by the PSI at the initial assessment and the first four reassessments. Two domain scores of parenting stress are provided, one focusing on child-related stress and one focusing on parent stress in other relationships. The child domain, or child-related stress, contains items related to the child's adaptation to change and transitions; the child's demands for attention or action; the child's negative expressions of mood, crying, withdrawal, and depression; and the child's hyperactivity and distractibility. The degree to which the child meets the parent's idealized expectations and the degree to which the child interacts positively with the parent are also assessed in the child domain. The parent domain assesses perceptions of depression, sense of competence, infringements on personal freedom, social isolation, support provided by the spouse, and parental health.

The two groups of families experienced similar levels of stress across reassessments #1 through #4 except for one statistically significant difference at reassessment #2. In that year, parents in the center-based only group reported statistically significantly less stress on the parent domain due to other relationships in the parent's life. Given the consistent pattern of no differences at all on other reassessments, this was probably the result of sampling fluctuation associated with the reduced sample size at reassessment #2. The families in both groups consistently experienced more child-related stress than parent-related stress, with child-related stress for both groups being at the 80th percentile or higher. Parent-related stress scores for both groups were at about the 75th percentile at reassessment #1, and approximately at the 66th percentile across reassessments #2 through #4. The two groups also reported similar levels of depression on the CES-D at reassessment #1.

At reassessment #5, the Comprehensive Evaluation of Family Functioning (CEFF) was administered to the parents in order to measure aspects of family functioning and stress. Higher scores indicated more problems. Scores for eight subscales and a total score based on six subscales (not including sibling relationships and situation stress subscales) are reported (see Table 9.11). No national norms are provided. The two groups reported similar stress on all the subscales. By dividing the total score of each group by the number of items, we have a mean rating of 2.3 for the center-based only group and 2.2 for the center-based with parent involvement group. On the scale, a rating of 2 indicates that these problems rarely occur. A rating of 3 indicates that these problems sometimes occur. These scores indicated that on

Table 9.11

Comparison of Reassessment Measures of Family Functioning for Subjects in Center-Based Only and Center-Based with Parent Involvement Groups (Reassessments #1 - #7) in the 1986 Utah Parent Involvement Study

		Center-Based					Center-Based + PIE							
Variable	Covariates'	$\bar{X}$	(SD)	Adj.$\bar{X}$#	%ile	n	$\bar{X}$	(SD)	Adj.$\bar{X}$#	%ile	n	F	p Value	ES^
REASSESSMENT #1														
•Parent Stress Index♦														
Child Related Range (47 to 235)	0,1,2,3	121.7	(23.5)	121.1	89	26	122.2	(16.8)	122.9	90	25	.15	.70	-.08
Other Related Range (54 to 270)	0,2,4,5	135.8	(31.8)	137.4	75	24	139.8	(21.6)	138.2	76	25	.03	.87	-.03
•Family Adaptation and Cohesion Evaluation Scales (FACES)'														
Adaptability Range (0 to 50)	4,6,8	25.3	(5.3)	25.0		28	24.8	(5.6)	25.1		27	.00	.95	.02
Cohesion Range (0 to 50)	7,9	37.0	(6.2)	37.6		27	41.0	(4.3)	40.4		28	6.21	.02	.45
•Family Support Scale (FSS)'	2,3,4	27.5	(10.4)	27.7	51	26	32.3	(10.5)	32.1	67	26	3.30	.08	.42
•Child Improvement Questionnaire-Revised*														
Professional		19.0	(3.6)			28	19.6	(3.6)			28	.31	.58	.17
Divine Intervention		11.3	(3.8)			28	10.5	(3.3)			28	.75	.39	.21
Parent		24.1	(3.9)			28	24.6	(2.3)			28	.29	.59	.13
Child		21.5	(3.9)			28	20.0	(3.5)			28	2.18	.15	-.38
Chance		9.2	(3.0)			28	9.8	(1.9)			28	.73	.40	-.20
•CES-D (depression)♣'		36.4	(12.4)			28	33.4	(11.7)			28	.89	.35	.24

(continued)

' Results computed among t-tests. Means are not adjusted.

Covariance adjusted means.

' 0 = PSI other related, 1 = PSI child related stress, 2 = FSS total score, 3 = BDI total score, 4 = FILE, 5 = Mother's work hours outside home, 6 = Mom's age at assessment, 7 = Dad's age at assessment, 8 = FACES assessment adaptability of family interaction patterns, 9 = FACES assessment cohesiveness of family interaction patterns, 10 = mothers years of education, 11 = fathers years of education, 12 = number of siblings receiving special education services, 13 = FRS total score, 14 = total income, 15 = child's age at assessment, 16 = child living with both parents, 17 = PSI total score, 18 = BDI communication Raw score, 19 = BDI pretest motor.

' Analyses for FSS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better. No norming sample is reported for these measures. To assist with interpretation, a percentile score is reported based on all assessments collected as a part of the Longitudinal Studies (currently, 645 families of children with handicaps).

' Scores for each subscale of the FACES are derived from the "ideal" score reported in the technical manual. Scores reported in the table indicate the distance from "ideal" in raw score units. A score of 0 is best (see Appendix A for details).

♦ Analysis for the PSI, FILE, and CEFF are based on raw scores. Lower scores represent less stress and are considered better. Both scales provide norms. High percentiles on the PSI represent more stress, while high percentiles on the FILE represent fewer stressful life events.

^
$$ES = \frac{\text{Center-Based + PIE Adj.}\bar{X} - \text{Center-based Adj.}\bar{X}}{\text{Center-Based SD}}$$

* Assesses parental perceptions of factors that affect child's developmental progress. Higher scores on professional, parent, and child domains are considered better. Lower scores on divine intervention and chance are considered better.

♣ Assesses parental depression; lower scores are better.

' Analyses for the CEFF are based on raw scores: Lower scores represent less stress and are considered better.

Table 9.11 (continued)

Comparison of Reassessment Measures of Family Functioning for Subjects in Center-Based Only and Center-Based with Parent Involvement Groups (Reassessments #1 - #7) in the 1986 Utah Parent Involvement Study

		Center-Based					Center-Based + PIE							
Variable	Covariates'	$\bar{x}$	(SD)	Adj.$\bar{x}$#	%ile	n	$\bar{x}$	(SD)	Adj.$\bar{x}$#	%ile	n	F	p Value	ES
REASSESSMENT #2														
•Parent Stress Index♦														
Child Related Range (47 to 235)	0,1,3,4,8	117.4	(19.9)	116.8	86	21	114.7	(16.2)	115.4	82	20	.14	.71	.07
Other Related Range (54 to 270)	0,4	126.8	(26.3)	127.8	63	21	137.8	(18.4)	136.7	75	20	4.07	.05	-.34
•Family Adaptation and Cohesion Evaluation Scales (FACES)'														
Adaptability Range (0 to 50)	7,8	24.7	(5.4)	24.6		20	25.9	(5.2)	26.0		20	1.39	.25	.26
Cohesion Range (0 to 50)	9	38.8	(5.8)	39.1		21	42.0	(3.9)	41.7		20	3.69	.06	.45
•Family Support Scale (FSS)'	0,2,4	29.8	(10.3)	30.5	63	20	31.9	(9.9)	31.3	63	19	.11	.74	.08
•Child Improvement Questionnaire-Revised*														
Professional	--	24.9	(5.2)			21	22.7	(4.6)			19	1.89	.18	-.42
Divine Intervention	--	14.2	(4.7)			21	11.4	(3.9)			19	4.19	.05	.60
Parent	--	28.8	(4.8)			21	27.8	(4.3)			19	.40	.53	-.21
Child	--	23.9	(4.3)			21	23.6	(4.3)			19	.06	.81	-.07
Chance	--	12.2	(3.6)			21	10.8	(3.0)			19	1.60	.21	.39
REASSESSMENT #3														
•Parent Stress Index♦														
Child Related Range (47 to 235)	1,10	119.3	(22.1)	118.5	87	26	116.6	(14.1)	117.4	86	23	.06	.81	.05
Other Related Range (54 to 270)	0,4,10	128.0	(27.0)	129.4	65	26	129.0	(15.7)	127.6	63	22	.13	.72	.07
•Family Adaptation and Cohesion Evaluation Scales (FACES)'														
Adaptability Range (0 to 50)	11,8	24.3	(5.3)	24.6		26	24.5	(4.4)	24.3		24	.08	.78	-.06
Cohesion Range (0 to 50)	9	35.9	(7.2)	36.5		26	38.1	(5.0)	37.5		24	.42	.52	.14
•Family Support Scale (FSS)'	2,4	30.5	(13.7)	30.4	59	26	26.5	(8.0)	26.6	46	23	1.76	.19	-.28
REASSESSMENT #4														
•Parent Stress Index♦														
Child Related Range (47 to 235)	1,3,10	118.0	(20.6)	117.6	87	28	112.8	(16.2)	113.3	79	23	.94	.34	.21
Other Related Range (54 to 270)	0,1,10,12	127.3	(25.1)	130.3	66	28	133.4	(16.6)	130.4	66	23	.00	.99	.00
•Family Adaptation and Cohesion Evaluation Scales (FACES)'														
Adaptability Range (0 to 50)	8	26.1	(6.2)	26.3		28	24.6	(5.2)	24.4		24	1.49	.23	-.31
Cohesion Range (0 to 50)	9,13	38.0	(6.0)	38.4		28	40.1	(4.3)	39.7		23	.99	.33	.22
•Family Support Scale (FSS)'	2,3,8	27.0	(9.7)	27.4	48	27	27.5	(8.4)	27.1	48	24	.01	.93	-.03
•Teacher Rating of Parents' Participation in Education Program:														
Attendance*		4.2	(1.2)			22	5.3	(1.8)			21	5.62	.02	.92
Support/Participation	14	15.1	(4.0)	14.9		21	17.9	(5.5)	18.1		19	4.91	.03	.80
Knowledge*		13.6	(3.6)			20	18.6	(7.9)			19	6.38	.02	1.39

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Table 9.11 (continued)

Comparison of Reassessment Measures of Family Functioning for Subjects in Center-Based Only and Center-Based with Parent Involvement Groups (Reassessments #1 - #7) in the 1986 Utah Parent Involvement Study

		Center-based only					Center-based + PIE							
Variable	Covariates'	$\bar{x}$	(SD)	Adj.$\bar{x}$*	%ile	n	$\bar{x}$	(SD)	Adj.$\bar{x}$*	%ile	n	ANCOVA F	p Value	ES
REASSESSMENT #5														
• Family Support (FSS)														
Family Support Total	2,7,16	27.3	(11.6)	27.8		28	26.4	(11.3)	25.8		24	.47	.50	-.17
• Family Functioning (CEFF)'														
Time Demands (0-30)	10	14.5	(5.6)	14.7		28	14.1	(5.7)	13.9		24	.27	.61	.14
Acceptance-Problems (0-55)	1,10	26.3	(6.7)	26.3		28	24.9	(4.2)	24.9		23	.88	.35	.21
Coping (0-35)	1	15.7	(5.2)	15.6		28	15.2	(4.0)	15.4		23	.03	.85	.04
Social Relationship (0-35)	1,10	15.1	(5.2)	15.2		28	13.6	(4.2)	13.5		23	1.69	.20	.33
Financial (0-10)		4.8	(2.6)	4.8		28	4.8	(1.8)	4.8		24	.01	.91	.00
Well Being (0-30)	4	15.0	(4.2)	15.2		28	14.5	(3.7)	14.4		24	.51	.48	.19
Sibling Relationship (0-60)	1	25.1	(11.7)	24.9		28	26.2	(8.6)	26.5		23	.30	.59	-.14
Situational Stress (0-55)	1	22.6	(9.3)	22.5		28	20.2	(9.0)	20.4		23	.67	.42	.23
Total (0-195)	8,16,17	91.5	(23.3)	90.0		28	86.7	(17.9)	88.2		23	.10	.75	.08
Total Number of Problems (0-39)	4,16	7.6	(8.5)	7.8		28	7.0	(8.3)	6.1		22	.54	.46	.20
• Family Function (APGAR)														
Adaptability (0-4)	10	2.9	(.9)	2.9		28	3.0	(.8)	3.1		24	.53	.47	.22
Partnership (0-4)	10.8	2.6	(.8)	2.6		28	2.9	(.8)	2.9		24	1.41	.24	.38
Growth (0-4)	10,8	2.4	(1.0)	2.4		28	2.8	(.7)	2.8		24	2.74	.10	.40
Affection (0-4)	10,8	2.9	(.9)	2.9		28	2.7	(.7)	2.7		24	.58	.45	-.22
Resolve (0-4)	10,8	2.9	(.8)	2.9		28	2.8	(.7)	2.8		24	.39	.54	-.13
Total (0-20)	10,8	13.7	(3.5)	13.7		28	14.2	(2.9)	14.2		24	.26	.62	.14
• Family Participation in Child's Educational Program														
Knowledge of Education Program	10	9.1	(2.3)	9.0		27	9.9	(2.1)	9.9		25	2.25	.14	.39
Support of Education Program	10,6	16.3	(3.4)	16.1		27	17.4	(3.1)	17.5		25	2.64	.11	.41
• Parent Self Awareness Scale Total Score	2,10,15,8	41.9	(8.4)	42.4	.89	27	41.6	(6.3)	41.1	.85	24	.39	.53	-.15
REASSESSMENT #6														
• Family Support (FSS)														
Family Support Total	2,9,16	27.1	(14.3)	27.8	26		27.8	(9.5)	27.0	48	.07	.80	.06	-.06
• Parent Stress Index+ (PSI-S) Short Form														
Parenting Distress	10,13	28.6	(10.1)	29.0	70	28	28.2	(7.0)	27.8	65	24	.25	.62	.12
Parent-Child Dysfunction	11,18	25.4	(7.3)	25.1	80	28	26.5	(6.9)	26.8	90	25	.91	.34	-.23
Difficult Child	11,13,18	31.5	(8.6)	31.2	80	28	30.2	(7.6)	30.5	80	24	.12	.73	.08
• Family Function (APGAR)														
Adaptability (0-4)	10	3.1	(.7)	3.1		28	3.4	(.6)	3.4		25	3.21	.08	.43
Partnership (0-4)	10,9	2.7	(.8)	2.7		28	2.9	(.6)	2.9		25	.79	.38	.25
Growth (0-4)	10,9	2.5	(.8)	2.5		28	3.0	(.6)	3.0		25	4.90	.03	.63
Affection (0-4)	10,9	2.8	(.9)	2.9		28	2.8	(.7)	2.8		25	.03	.87	-.11
Resolve (0-4)	10,9	3.0	(.7)	3.1		28	2.8	(.7)	2.7		25	2.47	.12	-.57
Total (0-20)	10,9	14.3	(3.2)	14.3		28	15.0	(3.0)	15.0		25	.70	.41	.22
•Family Participation in Child's Education Program														
Knowledge of Education Program	2	9.0	(2.4)	9.0		28	9.4	(2.4)	9.4		24	.49	.49	.17
Support of Education Program	2,6	16.2	(3.4)	16.0		28	17.1	(3.7)	17.3		24	1.99	.17	.38
• Parent Self Awareness Scale Total Score	1,2,15,9	42.4	(7.9)	42.6		26	43.4	(5.9)	43.2		24	.11	.75	.08
• Family Functioning Style Scale (FFSS)														
Family Identity	2,9	30.65	(6.5)	31.0		26	31.2	(3.8)	30.8		24	.02	.90	-.03
Information Sharing	2	11.0	(2.9)	11.0		26	11.8	(2.1)	11.8		24	1.15	.29	.28
Coping/Resource Mobilization	9,13	32.4	(7.4)	32.7		28	33.5	(3.8)	33.3		23	.13	.72	.08

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Table 9.11 (continued)

Comparison of Reassessment Measures of Family Functioning for Subjects in Center-Based Only and Center-Based with Parent Involvement Groups (Reassessments #1 - #8) in the 1986 Utah Parent Involvement Study

		Center-Based					Center-Based + PIE							
Variable	Covariates'	$\bar{x}$	(SD)	Adj.$\bar{x}$*	%ile	n	$\bar{x}$	(SD)	Adj.$\bar{x}$*	%ile	n	F	p Value	ES
REASSESSMENT #7														
• **Family Support (FSS)**														
Family Support Total	2,9,16	27.0	(13.0)	27.7	50	28	25.1	(7.2)	24.4	40	25	1.51	.23	-.25
• **Parent Stress Index* (PSI-S) Short Form**														
Parenting Distress	10,13	28.2	(10.2)	28.6	68	28	27.8	(7.5)	27.4	62	24	.23	.63	.12
Parent-Child Dysfunction	11,9	24.9	(9.0)	24.7	78	28	26.4	(8.4)	26.7	88	25	.79	.38	-.22
Difficult Child	11,13,18	31.2	(9.5)	31.1	80	28	31.7	(7.8)	31.8	81	24	.09	.76	-.07
• **Family Function (APGAR)**														
Adaptability (0-4)	10	3.0	(1.0)	3.0		28	3.2	(.6)	3.2		25	.72	.40	.20
Partnership (0-4)	10,9	2.7	(.8)	2.7		28	2.5	(.9)	2.5		25	1.49	.23	-.25
Growth (0-4)	10,9	2.6	(.8)	2.6		28	2.7	(.8)	2.7		25	.50	.48	.13
Affection (0-4)	10,9	2.9	(.7)	2.9		28	2.7	(.8)	2.7		25	.60	.44	-.29
Resolve (0-4)	10,9	2.7	(.8)	2.7		28	2.8	(.6)	2.8		25	.12	.74	.13
Total (0-20)	10,9	13.9	(3.3)	14.0		28	13.8	(3.3)	13.7		25	.08	.78	-.09
• **Family Participation in Child's Education Program**														
Knowledge of Education Program	10	9.3	(2.0)	9.2		28	9.5	(2.6)	9.5		23	.36	.55	.15
Support of Education Program	10,6	16.7	(3.9)	16.5		28	17.0	(3.7)	17.2		23	.36	.55	.18
• **Parent Self Awareness Scale Total Score**	2,10,15,9	44.1	(7.6)	44.5		28	43.6	(6.6)	43.2		25	.47	.50	-.17
• **Family Functioning Style Scale (FFSS)**														
Family Identity	2,9	29.3	(6.7)	29.9		28	31.4	(5.4)	30.8		25	.34	.56	.13
Information Sharing	2	10.3	(3.2)	10.3		28	11.9	(2.1)	11.9		25	4.93	.03	.50
Coping/Resource Mobilization	9,13	30.6	(6.3)	31.2		28	34.3	(5.3)	33.7		24	2.63	.11	.40
Dyadic Adjustment Scale (DAS)														
Dyadic Consensus	1	49.1	(8.4)	49.2		24	50.8	(5.9)	50.7		23	.52	.48	.18
Dyadic Satisfaction	11	39.8	(6.2)	39.8		24	39.0	(5.4)	39.0		24	.30	.59	-.13
Affectional Expression	11,8,19,12	9.1	(2.1)	8.8		24	8.4	(1.9)	8.7		24	.01	.91	-.05
Dyadic Cohesion	10	16.0	(4.2)	15.8		24	14.6	(3.9)	14.8		24	.84	.36	-.24
Total Dyadic Adjustment	11	114.0	(17.9)	114.1		24	112.8	(12.7)	112.8		24	.09	.76	-.07
REASSESSMENT #8														
• **Family Support (FSS)**														
Family Support Total	2,9,16	27.8	(13.4)	28.9	55	28	26.0	(9.8)	24.8	42	25	2.20	.14	-.31
• **Parent Stress Index* (PSI-S) Short Form**														
Parenting Distress	10,13	30.4	(10.8)	30.8	80	28	27.8	(6.0)	27.4	60	24	2.22	.14	.31
Parent-Child Dysfunction	11,9	26.5	(8.8)	26.3	85	28	26.2	(7.2)	26.4	85	25	.00	.98	-.01
Difficult Child	11,13,18	32.5	(9.8)	32.3	83	28	29.6	(6.0)	29.9	75	24	1.28	.26	.24
• **Family Participation in Child's Education Program**														
Knowledge of Education Program	10	9.1	(2.3)	9.0		27	9.3	(2.2)	9.4		21	.41	.52	.17
Support of Education Program	10,6	15.2	(3.5)	15.1		27	16.4	(4.4)	16.5		21	1.69	.20	.40
• **Parent Self Awareness Scale Total Score**	2,10,15,9	42.5	(9.7)	43.3		28	43.6	(6.2)	42.8		25	.07	.79	-.05
• **Family Functioning Style Scale (FFSS)**														
Family Identity	2,9	29.2	(5.8)	29.8		28	31.3	(5.8)	30.7		24	.32	.57	.16
Information Sharing	2	10.8	(2.8)	10.8		28	12.3	(2.3)	12.2		24	4.03	.05	.50
Coping/Resource Mobilization	9,13	30.6	(6.3)	31.2		28	34.3	(5.3)	33.7		24	2.63	.11	.40

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average, the problems listed in the CEFF were not considered to be frequent stresses. The total mean number of problems for each group (7.6 for the center-based only group and 7.0 for the center-based with parent involvement group) out of 39 problems listed also indicates that the families didn't consider themselves to be especially stressed.

At reassessments #6, #7 and #8, the PSI/SF scores revealed that the parents in both groups reported similar scores on the three domains (parenting distress, parent-child dysfunction, and difficult child). Their scores were all above average when compared to the national norms (see Table 9.11). The most stress was reported in the area of parent-child dysfunction.

Family functioning. Family adaptability and cohesion were the measures of family functioning for the preassessment and reassessments #1 through #4. No statistically significant differences were found between the mean group scores on family adaptability, and the relative position of the two groups with regard to being more adaptable changed at different reassessments. The adaptability scores averaged midway on the adaptability continuum (ranging from rigid to very flexible) (Olson & Tiesel, 1991).

The center-based with parent involvement group reported statistically significantly higher (better) cohesion scores at reassessments #1 and #2 than did the center-based only group. At reassessments #3 and #4 the center-based with parent involvement group reported more cohesion, though the differences between the two groups were not significant. It is worth noting that the cohesion scores generally increased each year for both groups. The cohesion scores (for both groups) were also midway in the cohesion continuum (ranging from disengaged to very connected) (Olson & Tiesel, 1991).

Family functioning was measured with the Family APGAR Scale at reassessments #5, #6 and #7. Subscales represent single items on this questionnaire of 5 items.

There were significant differences on one subscale score at reassessment #5 and on two subscales at reassessment #6, but no significant differences were found at reassessment #7. A total score representing satisfaction with family adaptability, partnership, growth, affection, resolve, is also provided. The two groups reported similar satisfaction across reassessments. The average mean for the five scales for both groups is almost 3, which is defined as "almost always satisfied."

An additional measure, the Family Functioning Style Scale was completed at reassessments #6, #7, and #8. This scale measures parent's perception about the family strengths in the dimensions of family identity, information sharing, and coping and resource mobilization. No statistically significant differences were found between the groups on the three family strength scales at reassessment #6. Only one statistically significant difference on the domain of information sharing was found at reassessment #7. At reassessment #8, both information sharing and coping/resources mobilization subscales were statistically significantly different. At each reassessment the center-based with parent involvement group reported more information sharing and a greater ability to cope with stressful situations and utilize their available resources. When the 3 scale scores were each averaged (dividing the scale total by the number of items), the average responses for both groups were 3's (on a scale of 0-4), which meant the statements were perceived as generally like their family and reflected a perception of general family strength.

Parent responsibility and effectiveness. The Child Improvement Questionnaire which measures the parent's perception of factors that affect the developmental progress of their child with disabilities was completed at reassessments #1 and #2. At neither reassessment did the parents in the two groups have a statistically significant difference in perceptions concerning the influence from professionals, divine intervention, parent, child, or chance, except for the perception concerning divine intervention as reassessment #2.

The Parent Self-Awareness Scale administered at reassessments #5, #6, #7, and #8 attempts to measure the parent's perception of her/his personal decision-making and information capabilities. The two groups of parents expressed similar beliefs concerning their capabilities.

Parent involvement in child's educational program. It is possible that participation in the parent involvement component might have influenced the parents' attitudes concerning their responsibility for and participation with interventionists in their child's education program. At reassessments #2, and #4, teachers rated the parents' participation in the educational program on a scale from (1) less than other parents to (3) more than other parents on 15 items. The items were summed into three variables (parent attendance, parent knowledge, and parent support). At reassessment #5, the scale was revised to 11 items, which were summed into two variables, parent knowledge and support. This same scale was completed at reassessment #6, #7, and #8. At reassessment #2, there were very few children in public school and no differences were seen between the groups in parent attendance, knowledge, and support. However, at reassessment #4, the group comparison (see Table 9.14) showed that the parents who participated in the PIE program were considered more knowledgeable about their children's education (p = .02, ES = 1.39), more supportive (p = .03, ES = .80), and attended more of the educational meetings (p = .02, ES = 1.39) than the parents in the center-based only group. At reassessments #5, #6, #7, and #8 the differences on these variables were not statistically significant, but the effect sizes (average effect size across four reassessments: knowledge = .22, support = .34) still favored the center-based with parent involvement group.

Families who were invited to join the parent-participation program appeared to experience some immediate gains in family functioning and some probable long-term benefits. Initial differences in family support were noted directly following the intervention. The scores for the center-based plus parent involvement group increased from before the intervention while scores for the center-based only group declined slightly. An immediate sense of increased family support was apparent for those who were invited to participate in the program. Families in the center-based plus parent involvement group also reported a statistically significant more amount of family cohesion through the first two reassessments. At reassessments #7 and #8, families in the center-based plus parent involvement group reported more information sharing and coping strategies with better resource mobilization. These results appear to be conceptually related and provide evidence for a possible benefit of the parent-involvement program. Families of children who have disabilities appear to benefit from parent participation as well as the children.

Other Analyses

The intervention analyzed in this report lends itself to other questions besides the primary group differences. Questions such as: 1) what is the effect on child development and family functioning for those who attended most of the parent involvement session versus those who were not invited and thus attended none? 2) are there correlates and variables that predict significant depression in the sample? 3) what are the effects of the intervention when the sample is divided according to their initial scores or demographics? and 4) is there a difference in the way parents and children interact as a result of the intervention? These additional questions are each discussed below.

Parent Attendance: Participation Comparison

A second question was addressed by comparing the group of parents in the center-based with parent involvement group who attended 11 or more of the PIE sessions, with the center-based only group. This is referred to as the participation comparison. Straightforward comparisons of all subjects in each group (center-based only vs. center-based with parent involvement) may not provide an adequate test of the effectiveness for this type of parent involvement program because data for parents who were invited, but did not attend regularly were included in the center-based with parent involvement group data. Attendance at the instructional sessions varied a great deal with a parent from one family not attending any of the 15 sessions, and a parent from one family attending all 15. On the average, the parents attended 9 of the 15 sessions. Thirteen parents attended 11 or more sessions, 6 parents attended 7 to 10 sessions, and 9 parents attended 6 sessions or less. Analyses were performed comparing the child development scores of the children whose parents attended most of the instructional sessions (11 or more) with those whose parents were in the center-based only group and were not invited to the PIE sessions (28). Parent outcome measures were also compared. These participation comparisons were completed to examine whether the parents who participated most extensively in the PIE program, realized greater benefits than those who did not participate in the parent involvement component (i.e., were in the center-based only group). The ability to generalize these results are limited by the small number (13) in the high attending group.

To compare group differences between the high-attending parent group and the center-based only group, preliminary analyses were performed to see how they matched on demographic and assessment variables, and to identify covariates. The demographic characteristics of the high-attending group and the center-based only group were very similar, with statistically significant differences on only 3 of 16 variables (see Table 9.12).

Child functioning. The differences in child development between the children of the high-attending parent group and the center-based only group are very similar to the differences found between the center-based only and the center-based with parent involvement group. The effect sizes on Table 9.13 and their covariates, usually the same scale taken at the initial assessment, demonstrated that the mean scores of the children whose parents were high attenders were greater on a large majority of the developmental scores across the eight reassessments. Ninety-eight of 112 scores favored the high-attending group, half of them by an effect size of

Table 9.12

Comparison on Key Demographic Variables of the Center-Based Only and High Attendance Groups in the 1986 Parent Involvement Study

	Center-Based Only			Attended 11 or more PIE				
	$\bar{x}$	(SD)	n	$\bar{x}$	(SD)	n	p Value	ES^
• Age of child in months as of 11/15/86	43.0	10.5	28	42.1	11.4	13	.80	-.09
• Age of mother in years	33.4	5.8	28	31.9	7.2	13	.48	-.26
• Age of father in years	35.9	6.2	27	35.0	8.4	13	.68	-.15
• Percent Male*	57.1		28	30.8		13	.12	-.47
• Years of Education--Mother	13.8	1.7	28	13.5	1.6	13	.56	-.18
• Years of Education--Father	13.8	2.1	28	14.3	2.2	13	.47	.24
• Percent with both parents living at home·	78.6		28	100.0		13	.07	.44
• Percent of children who are Caucasian*	82.1		28	92.3		13	.40	.17
• Hours per week mother employed	8.4	13.7	26	2.6	6.4	13	.16	-.42
• Hours per week father employed	42.8	15.5	21	43.5	15.7	13	.90	.05
• Percent of mothers employed*	42.9		28	15.4		13	.09	-.49
• Percent of fathers employed as technical managerial or above*	61.5		26	45.5		11	.38	-.29
• Total household income·	$21,785	$12,728	28	$22,961	$13,022	13	.79	.09
• Percent with mother as primary caregiver*	96.4		28	100.0		13	.50	.00
• Number of siblings	2.1	1.7	28	1.8	1.0	13	.52	-.18
• Number of siblings with disabilities	.1	.3	28	.4	.7	13	.03	1.00

* Statistical analyses for these variables were based on a t-test where those children or families possessing the trait or characteristic were scored "1," and those not possessing the trait were scores at "0."

· Income data were converted from categorical to continuous data by using the midpoint of each category.

Effect size is defined here as the difference between the groups (center + PIE minus center) on the ANCOVA scores, divided by the unadjusted standard deviation of the center-based intervention group. (See Glass, 1976; Tallmadge, 1977; & Cohen, 1977, for a more general discussion of the concept of Effect Size.) The sign of ES only indicates direction of difference; no value judgement is intended.

Table 9.13

Comparison of Reassessment Measures of Child Functioning for Children of Parents Who Attended 11 or More PIE Instruction Sessions, and Children of Parents in the Center-Based Only Group

		Center-based only				Attended 11 or more PIE Sessions						
Variable	Covariates[a]	$\bar{x}$	(SD)	Adj.$\bar{x}$[a]	n	$\bar{x}$	(SD)	Adj.$\bar{x}$[a]	n	ANCOVA F	p Value	ES
REASSESSMENT #1												
Battelle Developmental Inventory (BDI) Raw Scores for:												
Personal-Social	1,5,7◆	87.3	(28.0)	90.9	28	107.1	(25.6)	103.5	13	4.58	.04	.45
Adaptive Behavior	2,3,7	56.7	(15.4)	58.7	28	64.5	(12.9)	62.5	13	1.86	.18	.25
Motor	3,7	77.4	(23.9)	80.7	28	82.6	(24.1)	79.4	13	.17	.68	-.05
Communication	4,5,7	44.0	(16.4)	47.8	28	51.1	(20.8)	47.3	13	.03	.86	-.03
Cognitive	5,7	34.3	(13.7)	36.5	28	40.1	(15.1)	37.8	13	.26	.62	.10
Total	6,7	298.9	(20.1)	57.5	28	65.7	(13.7)	62.0	13	2.45	.13	.22
•Minnesota Child Development Inventory												
General Development	6	76.0	(22.9)	79.0	28	85.6	(16.8)	82.7	13	.73	.38	.16
REASSESSMENT #2												
Battelle Developmental Inventory (BDI) Raw Scores for:												
Personal-Social	1,5,7	101.7	(23.9)	103.3	20	119.1	(20.8)	117.5	10	6.57	.02	.59
Adaptive Behavior	2,3,7	67.4	(15.7)	68.3	20	74.0	(11.8)	73.1	10	1.67	.21	.31
Motor	3,7	92.4	(20.5)	94.5	20	100.5	(18.9)	98.4	10	1.00	.33	.19
Communication	4,5,7	50.4	(17.7)	54.1	20	60.4	(19.2)	56.7	10	.38	.55	.15
Cognitive	4,5,7	41.4	(16.2)	44.5	20	52.7	(17.5)	49.6	10	2.12	.16	.31
Total	6,7	353.2	(76.4)	363.3	20	406.7	(71.9)	396.6	10	5.41	.03	.44
REASSESSMENT #3												
Battelle Developmental Inventory (BDI) Raw Scores for:												
Personal-Social	1,5	113.8	(34.7)	116.4	26	132.7	(24.3)	130.1	11	2.48	.13	.40
Adaptive Behavior	2,3	73.3	(17.8)	75.2	26	83.8	(13.3)	82.0	11	2.50	.12	.38
Motor	3	93.2	(28.1)	97.0	26	104.0	(25.0)	100.3	11	.41	.53	.12
Communication	4,5	56.8	(22.6)	59.8	26	69.5	(19.9)	66.5	11	1.47	.23	.30
Cognitive	4,5	45.2	(17.2)	47.5	26	61.5	(21.9)	59.1	11	7.31	.01	.67
Total	6	382.4	(99.1)	393.7	26	450.6	(80.2)	439.3	11	3.57	.07	.46
REASSESSMENT #4												
Battelle Developmental Inventory (BDI) Raw Scores for:												
Personal-Social	1,5	128.8	(33.9)	131.5	28	142.2	(24.0)	139.5	12	1.00	.33	.24
Adaptive Behavior	2,3	79.1	(21.6)	80.9	28	90.0	(16.0)	88.3	12	1.78	.19	.34
Motor	3	101.4	(31.8)	104.7	28	114.6	(30.8)	111.3	12	1.07	.31	.21
Communication	4,5	64.4	(23.9)	68.5	28	79.1	(23.5)	74.9	12	1.49	.23	.27
Cognitive	4,5	59.8	(26.3)	63.4	28	72.6	(23.5)	69.0	12	.83	.37	.21
Total	6	433.5	(114.6)	447.3	28	498.4	(97.2)	484.7	12	1.88	.18	.33
Teacher Development SPECS ♦												
Communication	4	6.8	(1.7)	7.0	25	6.3	(2.1)	6.1	11	2.32	.14	-.53
Sensorimotor	3	14.0	(3.7)	14.3	25	15.0	(2.6)	14.7	11	.16	.69	.11
Physical		11.6	(1.7)		25	11.9	(1.8)		11	.19	.67	.18
Self-Regulation	4	13.8	(3.6)	14.1	25	15.8	(3.9)	15.5	11	1.15	.29	.39
Cognition	5	5.6	(2.3)	5.7	25	6.5	(2.1)	6.3	11	.49	.49	.26
Self/Social	1	12.7	(3.7)	12.8	25	14.7	(2.3)	14.6	11	2.42	.13	.49
School Placement •												
% not eligible for special education		4.0			25	10.0			10	.46	.50	.48
% time in typical classroom		26.3			26	43.6			10	1.70	.20	.35
% time in full-time special classroom		73.6			25	45.0			10	3.83	.06	.53

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[a] Covariates: 1 = BDI Personal-Social Assessment; 2 = BDI Adaptive Behavior Assessment; 3 = BDI Motor Assessment; 4 = BDI Communication Assessment; 5 = BDI Cognitive Assessment; 6 = BDI Total Assessment; 7 = Child Age Assessment, 8 = Number of siblings in home.

$$\widehat{ES} = \frac{(\text{Center-based + PIE Adj}.\bar{x}) - \text{Center-based Adj}.\bar{x}}{\text{Center-based SD}}$$

◆ Child's age at assessment correlated highly with the outcome measures for Assessments #1 and #2, but not at the later assessments. Therefore, it was used as a covariate only for Reassessments #1 and #2.

• Scores in this category represent percentages related to child's present educational placement. The questions for Reassessments #4 and #5 differed slightly from those used at Reassessment #6.

♦ These scales provide the parent and teacher's perception of the child's social skills and their problems. Higher scores represent more, either more skills or more problems.

Table 9.13 (continued)

Comparison of Reassessment Measures of Child Functioning for Children of Parents Who Attended 11 or More PIE Instruction Sessions, and Children of Parents in the Center-Based Only Group

		Center-based only				Attended 11 or more PIE Sessions						
Variable	Covariates&	$\bar{x}$	(SD)	Adj.$\bar{x}$#	n	$\bar{x}$	(SD)	Adj.$\bar{x}$#	n	ANCOVA F	p Value	ES^
REASSESSMENT #5												
Woodcock-Johnson Test of Achievement-Revised (WJ-R) for:												
Broad Knowledge	5	441.2	(29.7)	444.1	28	461.3	(20.4)	457.9	11	2.42	.13	.46
Skills Knowledge	5	384.3	(54.3)	389.5	28	427.6	(39.7)	421.7	11	3.83	.06	.59
Scale of Independent Behavior												
Motor Skills	3	435.5	(38.3)	439.0	28	447.3	(33.0)	443.9	12	.31	.58	.13
Social Communication Skills	6	454.2	(25.0)	456.6	28	467.7	(21.4)	465.2	12	1.54	.22	.34
Personal Living Skills	3	454.8	(26.8)	457.1	28	461.8	(20.3)	459.4	12	.15	.70	.09
Community Living Skills	6	430.2	(28.3)	432.8	28	446.6	(27.6)	444.0	12	1.74	.20	.40
Total	6	443.7	(24.1)	445.9	28	456.0	(20.5)	453.9	12	1.32	.26	.33
•Teacher Development SPECS♦												
Communication	4	6.5	(1.4)	6.6	28	6.9	(2.2)	6.8	12	.07	.79	.14
Sensorimotor	3	15.0	(2.6)	15.1	28	14.8	(2.6)	14.7	12	.23	.63	-.15
Physical		11.3	(2.2)		28	11.6	(2.0)		12	.16	.69	.14
Self-Regulation	4	13.7	(3.4)	14.1	28	14.7	(4.1)	14.2	12	.01	.93	.03
Cognition	5	5.4	(2.2)	5.6	28	6.3	(2.6)	6.1	12	.49	.49	.23
Self/Social	1	12.9	(3.5)		28	13.4	(3.6)		12	.04	.84	.14
•Social Skills Rating System (SSRS)▴												
Parent Evaluation of social skill	1	41.0	(16.4)	41.9	28	43.9	(14.4)	43.0	12	.05	.83	.07
Parent evaluation of problem behaviors		15.0	(4.5)		28	13.0	(5.9)		12	1.42	.24	.44
Teacher evaluation of social skills	1	30.9	(12.0)	31.6	28	30.6	(14.8)	29.9	12	.16	.69	-.14
Teacher evaluation of problem behaviors		13.5	(6.5)		28	11.5	(7.1)		12	.78	.38	.31
•Perceived Competence and Social Acceptance												
Cognitive Competence	5	20.8	(2.6)	20.9	21	19.8	(3.0)	19.6	10	1.72	.20	-.50
Physical Competence	3	16.4	(5.4)	16.7	21	16.1	(3.9)	15.8	10	.40	.54	-.17
Social Acceptance by peers		17.3	(4.2)		21	17.3	(5.2)		10	.00	.99	.00
Social Acceptance by mother		18.4	(3.8)		21	17.4	(3.9)		10	.49	.49	-.26
•School Placement▾												
% not eligible for special education		10.7			28	8.3			12	.05	.82	-.04
% in typical classroom	5	21.4		23.7	28	41.7		39.4	12	1.06	.31	.55
% in full-time special classroom	5	64.3		60.5	28	41.7		45.5	12	.88	.35	.52
REASSESSMENT #6												
•Woodcock-Johnson Test of Achievement-Revised (WJ-R) for:												
Broad Knowledge	3	450.8	(31.8)	451.6	28	469.8	(21.9)	466.1	11	1.63	.21	.46
Skills Knowledge	6	398.4	(54.0)	402.9	28	445.0	(39.4)	438.8	11	4.74	.04	.66
•Scale of Independent Behavior												
Motor Skills	3	440.0	(37.8)	443.5	28	447.3	(36.0)	443.8	12	.00	.98	.01
Social Communication Skills	6	457.6	(25.9)	459.9	28	468.1	(21.2)	465.8	12	.63	.43	.23
Personal Living Skills	6	458.1	(27.6)	460.0	28	466.9	(17.4)	465.1	12	.40	.53	.19
Community Living Skills	6	435.3	(28.4)	437.9	28	452.0	(24.5)	449.4	12	1.99	.16	.41
Total	6	447.9	(24.3)	450.0	28	458.8	(20.4)	456.6	12	.89	.35	.27
• Social Skills Rating System (SSRS)▴												
Parent evaluation of social skills	1	88.1	(25.4)	89.6	28	90.8	(24.6)	89.3	12	.00	.97	-.01
Parent evaluation of problem behaviors		108.5	(12.0)		28	96.3	(21.8)		12	5.25	.03	1.02
Teacher evaluation of social skill	1	88.6	(14.7)	89.3	28	96.2	(18.8)	94.5	11	.94	.34	.35
Teacher evaluation of problem behaviors		108.5	(18.3)		28	95.5	(11.4)		11	4.77	.04	.71
• Perceived Competence and Social Acceptance												
Cognitive Competence		18.7	(3.5)		23	20.4	(2.9)		10	1.84	.19	.49
Physical Competence	3	16.9	(5.2)	17.0	23	18.1	(4.7)	18.0	10	.28	.60	.19
Social Acceptance by Peers		17.2	(3.5)		23	18.3	(5.5)		10	.47	.50	.31
Social Acceptance by Mother		16.7	(3.9)		23	15.8	(4.6)		10	.29	.59	-.23
• School Placement▾												
% not eligible for special education		7.1			28	9.1			11	.04	.84	.26
% in typical classroom	5	19.2		25.1	26	50.0		44.1	10	1.42	.24	.35
% in full-time special classroom	5	80.8		74.9	26	50.0		55.9	10	1.42	.24	.35

Table 9.13 (continued)

Comparison of Reassessment Measures of Child Functioning for Children of Parents Who Attended 11 or More PIE Instruction Sessions, and Children of Parents in the Center-Based Only Group

		Center-based only				Attended 11 or more PIE Sessions						
Variable	Covariates'	$\bar{x}$	(SD)	Adj.$\bar{x}$'	n	$\bar{x}$	(SD)	Adj.$\bar{x}$'	n	ANCOVA F	p Value	ES
REASSESSMENT #7												
• **Woodcock-Johnson Test of Achievement-Revised (WJ-R)**												
Broad Knowledge	3	457.3	(32.1)	458.1	28	475.8	(32.1)	475.0	11	2.48	.12	.53
Skills Knowledge	6	407.5	(60.7)	411.9	28	455.1	(35.0)	450.7	11	4.40	.04	.64
• Scale of Independent Behavior												
Motor Skills	3	445.0	(36.9)	448.5	28	454.1	(40.4)	450.6	12	.05	.82	.06
Social Communication Skills	6	462.0	(27.1)	464.4	28	472.4	(18.6)	470.1	12	.59	.45	.21
Personal Living Skills	6	463.5	(28.2)	465.2	28	471.4	(20.1)	469.7	12	.27	.60	.16
Community Living Skills	6	445.5	(30.4)	447.8	28	457.1	(23.4)	454.8	12	.61	.44	.23
Total	6	454.1	(25.4)	456.1	28	463.8	(21.9)	461.7	12	.53	.47	.22
• **Social Skills Rating System (SSRS).**												
Parent evaluation of social skills	1	91.9	(23.9)	93.2	28	89.8	(22.9)	88.5	12	.46	.50	-.20
Parent evaluation of problem behaviors		107.8	(16.3)		28	105.0	(11.1)		12	.30	.59	.17
Teacher evaluation of social	1	87.1	(13.3)	87.6	28	102.9	(20.1)	102.4	11	7.49	.01	1.11
Teacher evaluation of problem behaviors		111.0	(12.4)		28	100.8	(17.8)		11	4.11	.05	.82
• **Perceived Competence and Social Acceptance**												
Cognitive Competence	5	19.0	(4.1)	19.2	25	21.2	(3.2)	20.0	10	1.56	.22	.20
Physical Competence	3,8	16.3	(5.2)	16.5	25	17.7	(4.2)	17.5	10	.45	.51	.19
Social Acceptance by Peers		18.0	(3.2)		25	18.0	(6.5)		10	.00	.98	.00
Social Acceptance by Mother		16.9	(2.8)		25	17.0	(5.1)		10	.00	.95	.04
• **School Placement·**												
% not eligible for special education	6	100.0			28	100.0			11			.00
% in typical classroom	6	39.3		39.9	28	54.5		54.0	11	.58	.45	.35
% in full-time special classroom	6	60.7		60.1	28	45.5		46.0	11	.58	.45	.35
REASSESSMENT #8												
• **Woodcock-Johnson Test of Achievement-Revised (WJ-R)**												
Broad Knowledge	3	458.5	(33.7)	459.5	28	482.1	(20.6)	481.0	11	3.75	.06	.64
Skills Knowledge	6	410.2	(61.5)	415.4	28	462.4	(38.5)	457.2	11	5.21	.03	.68
• **Scale of Independent Behavior**												
Motor Skills	3	443.3	(43.0)	447.3	28	459.9	(36.6)	455.9	12	.83	.37	.20
Social Communication Skills	6	465.6	(26.0)	467.6	28	480.0	(16.5)	477.6	12	1.84	.18	.39
Personal Living Skills	6	462.3	(26.6)	463.9	28	478.9	(19.6)	477.3	12	2.69	.11	.50
Community Living Skills	6	445.5	(26.9)	447.7	28	465.5	(22.8)	463.2	12	3.86	.06	.58
Total	6	454.3	(25.6)	456.2	28	471.1	(18.6)	469.1	12	3.01	.09	.50
• **Social Skills Rating System (SSRS).**												
Parent evaluation of social skills	1	90.6	(23.7)	91.6	27	96.7	(22.0)	95.6	12	.34	.57	.17
Parent evaluation of problem behaviors		108.0	(13.4)		27	102.9	(8.3)		12	1.43	.24	-.38
Teacher evaluation of social skills	1	88.3	(16.2)	89.0	27	100.1	(11.9)	99.4	10	3.47	.07	.64
Teacher evaluation of problem behaviors		110.9	(11.2)		27	102.6	(12.4)		10	3.82	.06	.74
• **Perceived Competence and Social Acceptance**												
Cognitive Competence	5	18.7	(4.0)	18.8	23	20.9	(3.0)	20.8	11	2.15	.15	.50
Physical Competence	3,8	16.9	(5.6)	17.2	23	17.5	(4.6)	17.2	11	0	.99	0
Social Acceptance by Peers		17.7	(4.1)		23	18.2	(4.8)		11	.09	.76	.12
Social Acceptance by Mother		16.4	(4.1)		23	16.3	(4.9)		11	.01	.92	-.02
• **School Placement·**												
% not eligible for special education	6	3.8		3.5	26	9.1		9.5	11	.49	.49	.45
% in typical classroom	6	65.4		67.3	26	81.8		79.9	11	.56	.46	.37
% in full-time special classroom	6	34.6		32.7	26	18.2		20.1	11	.56	.46	.37

one-third of a standard deviation or more. While only 19 of the comparisons showed a statistically significant advantage for the high-attending group there were no statistically significant advantages for the center-based only group.

It is interesting to note that the BDI total score statistically significantly favored the high-attending group at reassessments #2 and #3, and the personal/social score at reassessments #1 and #2. The high-attending group had some long-term benefits in skills knowledge as measured by the Woodcock-Johnson at reassessments #5 through #8. At reassessment #8, the high-attending group also scored statistically significantly higher on the broad knowledge score.

The children's social skills and problem behaviors, as perceived by the parents and teachers, also showed statistically significant differences. At reassessment #6, both teachers and parents reported the high-attending group had fewer problem behaviors than the center-based only group. Reassessments #7 and #8 showed the teachers--but not the parents--still perceiving a statistically significant difference on both social skills and problem behaviors favoring the high-attending group.

Although the same general pattern of statistically significant results were present in the center-based plus parent involvement group comparison (the primary question in this study), these analyses added an important dimension not available in the other analysis. The decrease in sample size for the high-attending analysis would theoretically make obtaining statistical significance less likely; however, this was not the case. Important differences were still statistically significant and at an even higher alpha level in most cases. Furthermore, the effect sizes (not dependent upon sample size) showed greater differences between the two groups. Analysis comparing the high and low attenders is not practical given the small number of participants, but tentative conclusions can be drawn that regular attendance at the parent-involvement sessions may have had a significant impact on certain aspects of subsequent child development and behavior.

Family functioning. Across reassessments, center-based and high-attending groups did not differ significantly on parenting stress (measured by PSI), except at reassessment #8 where center-based only group reported significantly more parenting distress.

The social support (FSS) and family adaptability (FACES III) (see Table 9.14) failed to reach statistical significance. However, family cohesion (FACES III) scores were statistically significantly different at reassessments #1 (p value = .006, ES = .68), #2 (p value = .03, ES = .73), and #4 (p value = .10, ES = .50), with the

Table 9.14

Comparison of Reassessment Measures of Family Functioning of Parents Who Attended 11 or More PIE Instruction Sessions, and Parents in the Center-Based Only Group

		Center-based only				Attended 11 or more PIE Sessions						
Variable	Covariates$	$\bar{x}$	(SD)	Adj.$\bar{x}$#	n	$\bar{x}$	(SD)	Adj.$\bar{x}$#	n	F	p Value	ES
REASSESSMENT #1												
•Parent Stress Index♦												
Child Related Range (47 to 235)	0,1,2,3	121.7	(23.6)	119.3	26	120.1	(21.3)	122.6	11	.24	.63	-.14
Other Related Range (54 to 270)	0,2,4,7	135.8	(31.8)	136.9	24	135.7	(19.2)	134.6	11	.12	.73	.07
•Family Adaptation and Cohesion Evaluation Scales (FACES)+												
Adaptability Range (0 to 50)	9,11	25.3	(5.3)	24.9	28	23.9	(7.3)	24.2	13	.12	.73	-.13
Cohesion Range (0 to 50)	10,12	37.0	(6.2)	38.2	27	42.2	(4.3)	41.0	13	3.44	.07	.45
•Family Support Scale (FSS)&	2,3,4	27.5	(10.4)	28.6	26	31.6	(10.8)	30.5	12	.39	.54	.18
•Child Improvement Questionnaire-Revised*												
Professional		19.1	(3.6)		28	18.9	(3.7)		13	.03	.85	-.06
Divine Intervention		11.3	(3.8)		28	8.9	(2.5)		13	4.25	.05	-.63
Parent		24.1	(3.9)		28	24.9	(1.8)		13	.42	.52	.21
Child		21.5	(3.9)		28	20.0	(3.2)		13	1.38	.25	-.38
Change		9.2	(3.0)		28	9.3	(1.4)		13	.02	.88	.03
•CES-D (parental depression)♣		36.4	(12.4)		28	31.5	(8.3)		13	1.63	.21	.40

° Results computed among t-tests. Means are not adjusted.

Covariance adjusted means.

$ 0 = PSI other related stress, 1 = Child related stress, 2 = FSS total score, 3 = BDI total score, 4 = FILE, 5 = Mother's years of education, 6 = Father's years of education, 7 = Mother's work hours outside home, 8 = Child's age at pretest, 9 = Mom's age at pretest, 10 = Dad's age at pretest, 11 = FACES pretest adaptability of family interaction patterns, 12 = FACES pretest cohesiveness of family interaction patterns, 13 = Number of siblings receiving special ed. services, 14 = FRS total score, 15 = Child living with both parents, 16 = PSI total score, 17 = Total income, 18 = Mother's occupation, 19 = BDI communication raw score, 20 = BDI motor raw score.

& Analyses for FSS are based on raw scores indicating number of supports or resources indicated by the family as being available. Higher scores and positive ESs are considered better. No norming sample is reported for these measures. To assist with interpretation, a percentile score is reported based on all pretests collected as a part of the Longitudinal Studies (currently, 645 families of children with disabilities).

+ Scores for each subscale of the FACES are derived from the "ideal" score reported in the technical manual. Scores reported in the table indicate the distance from "ideal" in raw score units. A score of 0 is best (see Appendix A for details).

♦ Analysis for the PSI, FILE, and CEFF are based raw scores. Lower scores represent less stress and are considered better. Both scales provide norms. High percentiles on the PSI represent more stress, while high percentiles on the FILE represent fewer stressful life events.

^ $$ES = \frac{(\text{Center-based + PIE Adj.x}) - \text{Center-based Adj.x}}{\text{Center-based SD}}$$

* Assesses parental perceptions of factors that affect child's development progress.

♣ Assesses parental depression.

Table 9.14 (continued)

Comparison of Reassessment Measures of Family Functioning of Parents Who Attended 11 or More PIE Instruction Sessions, and Parents in the Center-Based Only Group

		Center-based only				Attended 11 or more PIE Sessions						
Variable	Covariates'	$\bar{x}$	(SD)	Adj.$\bar{x}$'	n	$\bar{x}$	(SD)	Adj.$\bar{x}$'	n	F	p Value	ES
REASSESSMENT #2 **•Parent Stress Index***												
Child Related Range (47 to 235)	0,1,3,4,12	117.4	(19.9)	116.7	21	110.5	(15.8)	111.2	10	1.51	.23	.28
Other Related Range (54 to 270)	0,4	126.8	(26.3)	126.5	21	133.1	(16.5)	133.4	10	1.60	.22	-.26
•Family Adaptation and Cohesion Evaluation Scales (FACES)+												
Adaptability Range (0 to 50)	10,11	24.7	(5.4)	24.1	20	24.5	(6.3)	25.2	10	.52	.48	.20
Cohesion Range (0 to 50)	12	38.8	(5.8)	39.3	21	44.0	(3.3)	43.5	10	4.80	.04	.72
•Family Support Scale (FSS)&	0,2,3	29.8	(10.3)	30.8	20	31.2	(12.9)	30.2	9	.03	.86	-.06
•Child Improvement Questionnaire-Revised@												
Professional		24.9	(5.2)		21	21.9	(4.7)		9	2.18	.15	-.58
Divine Intervention		14.2	(4.7)		21	11.0	(4.1)		9	3.10	.09	-.68
Parent		28.8	(4.8)		21	29.0	(3.2)		9	.02	.89	.04
Child		23.9	(4.4)		21	24.2	(4.8)		9	.03	.86	.07
Change		12.2	(3.6)		21	10.8	(3.2)		9	1.02	.32	-.39
REASSESSMENT #3 **•Parent Stress Index***												
Child Related Range (47 to 235)	1,5	119.3	(22.1)	118.5	26	115.3	(16.9)	116.1	9	.16	.69	.11
Other Related Range (54 to 270)	4,5	128.0	(27.8)	129.1	26	128.2	(12.7)	127.1	9	.08	.78	.07
•Family Adaptation and Cohesion Evaluation Scales (FACES)+												
Adaptability Range (0 to 50)	11	24.4	(5.3)	23.8	26	23.9	(4.7)	24.5	10	.25	.62	.13
Cohesion Range (0 to 50)	12	35.9	(7.2)	37.5	26	39.4	(4.1)	37.9	10	.04	.84	.06
•Family Support Scale (FSS)&	2,4	30.5	(13.8)	31.1	26	27.8	(9.9)	27.2	10	1.04	.32	-.28
REASSESSMENT #4 **•Parent Stress Index***												
Child Related Range (47 to 235)	1,3,5	118.0	(20.6)	116.8	28	112.7	(18.9)	114.0	11	.25	.62	.14
Other Related Range (54 to 270)	0,1,5,13	127.3	(25.1)	130.8	28	134.1	(16.5)	130.6	11	.00	.98	.01
•Family Adaptation and Cohesion Evaluation Scales (FACES)+												
Adaptability Range (0 to 50)	11	26.1	(6.2)	25.8	28	26.4	(5.2)	26.7	12	.23	.63	.15
Cohesion Range (0 to 50)	12,14	38.0	(6.0)	38.6	28	42.2	(3.2)	41.6	11	2.50	.12	.50
•Family Support Scale (FSS)&	2,3,11	27.0	(9.7)	27.5	27	30.1	(9.6)	29.6	12	.52	.48	.22
•Teacher Rating of Parents' Participation in Education Program												
Attendance		4.2	(1.2)		22	5.8	(2.2)		11	7.71	.01	1.33
Support/Participation	17	15.1	(4.1)	15.0	21	20.4	(6.6)	20.6	9	8.78	.01	1.37
Knowledge		13.6	(3.6)		20	19.8	(6.8)		9	10.55	.00	1.72

Table 9.14 (continued)

Comparison of Reassessment Measures of Functioning of Parents Who Attended 11 or More PIE Instruction Sessions, and Parents in the Center-Based Only Group

		Center-based only				Attended 11 or more PIE Sessions						
Variable	Covariates*	$\bar{x}$	(SD)	Adj.$\bar{x}$*	n	$\bar{x}$	(SD)	Adj.$\bar{x}$*	n	F	p Value	ES
REASSESSMENT #5												
• **Family Support (FSS)**												
Family Support Total	2,12	27.3	(11.6)	27.3	28	27.7	(12.1)	27.6	12	.01	.92	.03
• **Family Functioning (CEFF)♦**												
Time Demands (0-30)	5	14.5	(5.6)	14.7	28	15.2	(5.4)	14.9	12	.01	.93	-.04
Acceptance-Problems (0-55)	1,5	26.3	(6.7)	26.4	28	24.3	(4.7)	24.2	11	1.01	.32	.33
Coping (0-35)	1	15.7	(5.2)	15.5	28	14.7	(3.7)	15.0	11	.08	.77	.10
Social Relationship (0-35)	1,5	15.1	(5.3)	15.2	28	13.8	(4.3)	13.8	11	.67	.42	.26
Financial (0-10)		4.8	(2.6)		28	5.1	(1.9)		12	.10	.76	.12
Well Being (0-30)	5	15.0	(4.2)	15.4	28	15.4	(3.4)	15.1	12	.05	.82	.07
Sibling Relationship (0-60)		25.1	(11.7)		28	24.0	(7.7)		12	.10	.76	.09
Situational Stress (0-55)	1	22.6	(9.3)	22.3	28	19.9	(7.2)	20.2	11	.46	.50	.23
Total (0-195)	12,16	91.5	(23.3)	91.4	28	87.9	(20.1)	88.0	11	.20	.66	.15
Total Number of Problems (0-39)	1	7.6	(8.5)	7.5	28	6.3	(8.9)	6.4	11	.13	.72	.13
• **Family Function (APGAR)**												
Adaptability (0-4)	5	2.9	(.9)	2.9	28	3.2	(.6)	3.2	12	1.53	.22	.33
Partnership (0-4)	5,11	2.6	(.8)	2.6	28	2.8	(.6)	2.8	12	.70	.41	.25
Growth (0-4)	5,11	2.4	(1.0)	2.4	28	2.9	(.8)	2.9	12	2.99	.09	.50
Affection (0-4)	5,11	2.9	(.9)	2.9	28	2.8	(.6)	2.8	12	.09	.77	-.11
Resolve (0-4)	5,11	2.9	(.8)	2.9	28	2.7	(.8)	2.6	12	1.11	.30	-.38
Total (0-20)	5,11	13.7	(3.5)	13.7	28	14.3	(2.7)	14.3	12	.34	.57	.17
•**Family Participation in Child's Educational Program**												
Knowledge of Education Program	5	9.1	(2.3)	9.0	27	11.0	(1.3)	11.1	12	8.77	.01	.91
Support of Education Program	5,9	16.3	(3.4)	16.1	27	18.8	(2.3)	19.0	12	8.17	.01	.85
• Parent Self Awareness Scale Total Score	2,5,8,11	41.9	(8.4)	42.4	27	41.5	(5.8)	41.0	12	.36	.56	-.17
REASSESSMENT #6												
• **Family Support (FSS)**												
Family Support Total	2,11	27.4	(14.6)	27.8	28	30.1	(10.2)	29.7	12	.25	.62	.13
• **Parent Stress Index♦** (PSI-S) Short Form												
Parenting Distress	5,14	28.6	(10.1)	29.5	28	30.0	(8.2)	29.1	11	.01	.91	.04
Parent-Child Dysfunction	6,19	25.4	(7.3)	24.5	28	27.3	(8.5)	28.2	12	2.53	.12	-.51
Difficult Child	6,14,19	31.5	(8.6)	30.6	28	31.5	(9.7)	32.4	11	.37	.55	-.21
• **Family Function (APGAR)**												
Adaptability (0-4)	5	3.1	(.8)	3.1	28	3.4	(.5)	3.5	12	2.71	.11	.50
Partnership (0-4)	4,11	2.7	(.8)	2.7	28	2.8	(.6)	2.7	12	.00	.96	.00
Growth (0-4)	4,11	2.5	(.8)	2.5	28	2.9	(.5)	3.0	12	3.53	.07	.63
Affection (0-4)	4,11	2.8	(.9)	2.8	28	2.6	(.8)	2.6	12	.59	.45	-.22
Resolve (0-4)	4,11	3.0	(.7)	3.0	28	2.8	(.8)	2.8	12	1.16	.29	-.29
Total (0-20)	4,11	14.3	(3.2)	14.2	28	14.4	(2.6)	14.5	12	.08	.78	.09
•**Family Participation in Child's Educational Program**												
Knowledge of Education Program	5	9.0	(2.4)	8.8	28	10.7	(1.6)	10.9	11	7.29	.01	.88
Support of Education Program	5,9	16.2	(3.4)	15.9	28	19.2	(1.9)	19.4	11	13.15	.00	1.03
• Parent Self Awareness Scale Total Score	2,5,11	42.3	(8.2)	42.2	28	42.4	(5.8)	42.5	12	.01	.92	.04
• **Family Functioning Style Scale** (FFSS)												
Family Identity	2,11	30.6	(6.8)	31.3	28	31.9	(2.8)	31.3	12	.00	.98	.00
Information Sharing	2	11.0	(2.9)	11.1	28	12.1	(2.3)	12.0	12	1.07	.31	.31
Coping/Resource Mobilization	11,14	32.4	(7.4)	32.9	28	34.1	(3.7)	33.6	11	.10	.75	.09

Table 9.14 (continued)

Comparison of Reassessment Measures of Family Functioning of Parents Who Attended 11 or More PIE Instruction Sessions, of Parents in the Center-Based Only Group

		Center-based only				Attended 11 or more PIE Sessions						
Variable	Covariates*	$\bar{x}$	(SD)	Adj. $\bar{x}$*	n	$\bar{x}$	(SD)	Adj. $\bar{x}$*	n	F	p Value	ES
REASSESSMENT #7												
• **Family Support** (FSS)												
Family Support Total	2,11	27.0	(13.0)	27.7	28	26.9	(5.9)	26.3	12	.17	.68	-.11
• **Parent Stress Index*** (PSI-S) Short Form												
Parenting Distress	5,14	28.2	(10.2)	29.1	28	26.1	(7.4)	25.2	11	1.50	.23	.38
Parent-Child Dysfunction	6	24.9	(9.0)	24.7	28	27.8	(10.9)	27.9	12	1.00	.32	-.35
Difficult Child	6,14	31.2	(9.5)	31.1	28	34.1	(7.7)	34.2	11	1.16	.29	-.33
• **Family Function (APGAR)**												
Adaptability (0-4)	5	3.0	(1.0)	3.0	28	3.3	(.6)	3.3	12	1.22	.28	.30
Partnership (0-4)	5,11	2.7	(.8)	2.7	28	2.3	(.8)	2.3	12	2.58	.12	-.50
Growth (0-4)	5,11	2.6	(.8)	2.6	28	2.8	(.6)	2.9	12	1.45	.24	.38
Affection (0-4)	5,11	2.9	(.7)	2.9	28	2.7	(.7)	2.7	12	.55	.46	-.28
Resolve (0-4)	5,11	2.7	(.8)	2.7	28	2.8	(.6)	2.8	12	.25	.62	.13
Total (0-20)	5,11	13.9	(3.3)	13.9	28	13.8	(2.9)	13.7	12	.04	.85	-.06
•**Family Participation in Child's Educational Program**												
Knowledge of Education Program	5	9.3	(2.0)	9.2	28	11.2	(.9)	11.3	11	14.03	.00	1.05
Support of Education Program	5	16.7	(3.9)	16.4	28	19.4	(1.9)	19.6	11	6.73	.01	.82
• **Parent Self Awareness Scale** Total Score	2,5,11	44.1	(7.6)	44.1	28	42.5	(6.0)	42.5	12	.52	.48	-.21
• **Family Functioning Style Scale** (FFSS)												
Family Identity	2,11	29.3	(6.7)	30.0	28	33.1	(5.1)	32.3	12	1.26	.27	.34
Information Sharing	2	10.3	(3.2)	10.3	28	12.3	(2.1)	12.2	12	3.83	.06	.59
Coping/Resource Mobilization	11,14	30.6	(6.3)	31.3	28	35.9	(4.4)	35.2	11	3.93	.06	.62
•**Dyadic Adjustment Scale (DAS)**												
Dyadic Consensus	1	49.1	(8.5)	49.4	24	51.7	(5.0)	51.4	11	.62	.44	.24
Dyadic Satisfaction	6	39.8	(6.2)	39.9	24	39.3	(5.6)	39.3	12	.09	.76	-.10
Affectional Expression	12,13,20	9.1	(2.1)	8.7	24	7.8	(2.5)	8.3	12	.22	.64	-.19
Dyadic Cohesion	5	16.0	(4.2)	15.7	24	14.7	(2.9)	14.9	12	.36	.55	-.19
Total Dyadic Adjustment	6	114.0	(17.9)	114.2	24	113.6	(12.4)	113.4	12	.02	.88	-.04
REASSESSMENT #8												
• **Family Support** (FSS)												
Family Support Total	2,11	27.8	(13.4)	28.9	28	29.1	(10.0)	27.9	12	.10	.75	-.07
• **Parent Stress Index*** (PSI-S) Short Form												
Parenting Distress	5,14	30.4	(10.8)	31.6	28	25.0	(3.1)	23.7	11	8.53	.01	-.73
Parent-Child Dysfunction	6	26.5	(8.8)	25.9	28	27.3	(7.5)	27.9	12	.55	.46	.23
Difficult Child	6,14	32.5	(9.8)	31.6	28	31.5	(6.1)	32.4	11	.08	.78	.08
•**Family Participation in Child's Educational Program**												
Knowledge of Education Program	5	9.1	(2.3)	8.9	27	10.5	(1.2)	10.7	10	5.49	.03	.78
Support of Education Program	5	15.2	(3.5)	15.0	27	19.0	(2.1)	19.2	10	13.46	.001	1.2
• **Parent Self Awareness Scale** Total Score	2,5,11	42.5	(9.7)	43.3	28	43.3	(4.9)	42.5	11	.11	.75	-.08
• **Family Functioning Style Scale** (FFSS)												
Family Identity	2,11	29.2	(5.8)	30.0	28	33.3	(4.4)	32.5	12	2.27	.14	.43
Information Sharing	2	10.8	(2.8)	10.9	28	12.8	(1.7)	12.7	12	4.7	.04	.64
Coping/Resource Mobilization	11,14	31.3	(6.6)	31.7	28	37.2	(3.7)	36.7	11	5.5	.03	.75

families in the high-attending group reporting more positive scores. At reassessment #5, no differences were found on the family functioning measures (as measured by the CEFF and APGAR) except for one subdomain on the Family APGAR scale. In sum, the findings on child and family functioning in this participation comparison are similar to, but are no stronger than, the findings of the comparisons of the total center-based with parent involvement group and the center-based only group.

One significant advantage is seen for the high-attending group of parents over the parents in the center-based only group across reassessments #4 through #7. The current school teachers consistently rated this group of parents as being significantly more knowledgeable and more supportive of their children's educational programs. The differences which are statistically significant at each reassessment (all p values are .01), and the average effect sizes demonstrate a difference between the groups of slightly more than one standard deviation.

Symptoms of depression. At reassessment #1, using the CES-D as a measure of depression, 30% of an expanded sample (N = 131) was classified in the "clinical" range. The mean for this sample of mothers of children with disabilities was 12.2 (SD = 10.6), almost one half a standard deviation above the mean of the normative CES-D sample (ES = .53).

To investigate the relationship between CES-D scores and several child and family variables, a number of correlational analysis were performed. Correlations between the CES-D and demographic variables were quite low and ranged between -.23 (the only significant correlation) to .08. Likewise, correlations with child functioning (as measured by the BDI) ranged from -.09 to .15. However, correlations between family functioning and the CES-D were much larger. These scores ranged from .16 for family adaptability (FACES III) to -.40 for resources (FRS) and .36 for stressors in the previous year (FILE). Parenting stress (PSI) also provided significant correlations, but more in the parent domain scales than the child domain scales. The parent domain of the PSI included measures of perceptions of depression, sense of competence, parental attachment, health, spousal relationships, and social isolation.

To explore which variables best predicted maternal depression, a series of regression equations were performed. Forty-one percent of the variance was explained when the PSI parent related stress subscale was included in the equation. The optimal models without the PSI explained 30% of the CES-D scores with scores from the FRS, FSS and FILE being significant predictors.

It has been hypothesized that mothers of children with disabilities are at greater risk for depressive symptamology than other mothers. This analysis provided limited support for this hypothesis. It is important to note that depression was not related to the child's level of development or health. This implies that the degree of a child's impairment is not necessarily related to the mother's emotional state. Furthermore, the Child Domain subscales of the PSI did not correlate with CES-D nearly as high as the Parent Domain subscales. This indicates that issues associated with finances and social support are more related to maternal depression than issues of child behavior. These findings, coupled with the fact that the number of life stressors also correlated significantly, lends support to this assertion. Taken together, results of this analysis indicate maternal depression is more related to the additional burdens of time and money associated with rearing a child with disabilities than it is to the quality of the relationship between the parent and the child or the specific characteristics of the child.

A final analysis correlated the parent's score on the CES-D with the videotaped parent-child interaction scales; namely: the Parent/Caregiver Involvement Scale and the Maternal Behavior Rating Scale. These correlations were generally quite low. This finding is important because of its implications. Depressive symptoms are not necessarily reflected in the parent-child relationship. It is possible that mothers of children with disabilities are able to hide their emotional distress from their young children with disabilities in a way that does not affect their relationship.

Parent-child interaction. An important analysis that has not been reported earlier involves the observed interaction that occurred between each child and their parent. Did adding a parent-involvement component to an early intervention program influence parents' interactions with their children? Parent interaction behaviors were measured via ratings of videotaped sequences of the mother and child interacting in a free-play setting. The videotapes of parent-child interaction were collected at reassessments #1, #2, and #4. Then they were coded by two different parent-child interaction rating systems; including the Parent/Caregiver Involvement Scale (PCIS) (Farran et al., 1986), and the Parental Behavior Rating Scale (PBRS) (Mahoney, 1988). The codings were completed by persons who were supervised and/or trained by the developers of each coding system. They were uninformed about the research hypotheses under investigation. Reassessment #1 and #2 videotapes were coded with both the PCIS and the PBRS coding systems; reassessment #4 videotapes were only coded with the PBRS system.

The PCIS scale (i.e., Farran scale) measures 11 parent or caregiver behaviors. These scales include: physical involvement, verbal involvement, responsiveness, play interaction, teaching behavior, control, directives, relationship among activities in which caregiver was involved, positive statements, negative statements/discipline, and goal setting. Each of the caregiver behaviors were rated separately for the amount, quality and appropriateness using a five point Likert scale. The means of the 11 scores in each of the three areas resulted in three single scores. The amount, quality and appropriateness scores were then correlated with the initial demographic and outcome measures to identify covariates. Statistical, practical, and consistent correlations were found between the quality and appropriateness scores with the number of siblings in the home. Correlations for the amount score did not meet the criteria for inclusion as a covariate. An analysis of (co)variance was completed on the three scores between the center-based plus parent involvement group and the center-based only group for reassessments #1 and #2. Results are listed in Table 9.15. No differences were found between groups on total amount of behaviors observed. The parents in the center-based with parent involvement were rated statistically significantly higher in quality of interaction than the parents in the center-based only group at reassessment #1 (p = .03, ES = .57). The advantage for the parent involvement group on appropriateness did not reach the .10 level of significance but had an effect size of 1/3 of a standard deviation. The scores at reassessment #2 were not statistically significant.

The PBRS (Mahoney) rates 12 parental behaviors including warmth, expressiveness, enjoyment, acceptance, sensitivity to child's interest, responsivity, effectiveness, directiveness, achievement orientation, pace, inventiveness, and verbal praise. Based on a maximum likelihood factor analysis with oblique rotation (using SPSS-PC procedures) of these 12 variables for 237 observations of parent-child interaction from the EIRI studies, 3 factors were identified which together accounted for 59.6% of the variance. Factor 1, Affective Relationship with Child, included expressiveness toward child, warmth, enjoyment of interacting with child, acceptance of child's behaviors, and inventiveness in play. For Factor 2, Responsivity to Child, sensitivity to child's

Table 9.15

Comparison of Parental Behaviors as Coded by the PCIS (Farran) For Parents in the Center-Based Only and Center-Based with Parent Involvement Groups for Reassessments #1 and #2

		Center-Based				Center-Based + PIE						
Variable	Covariates[a]	$\bar{x}$	(SD)	Adj.$\bar{x}$[c]	n	$\bar{x}$	(SD)	Adj.$\bar{x}$[c]	n	ANCOVA F	p Value	ES
REASSESSMENT #1												
Average Rating:												
Amount		2.8	(.6)		26	2.7	(.4)		22	.47	.50	-.17
Quality	1	3.7	(.7)	3.7	26	4.1	(.6)	4.1	22	4.06	.05	.57
Appropriateness	1	3.9	(.6)	3.9	26	4.2	(.7)	4.1	22	1.75	.19	.33
REASSESSMENT #2												
Total Rating:												
Amount		3.0	(.6)		19	3.0	(.6)		17	.05	.83	.00
Quality	1	3.9	(.9)	3.9	19	4.2	(.6)	4.2	17	.77	.39	.33
Appropriateness	1	4.1	(.9)	4.1	19	4.3	(.8)	4.2	17	.95	.51	.11

[a] 1 = Number of siblings in the home.

[b] Involvement was rated (with a Likert-type scale, range 1-5) over 11 parent/caregiver behaviors (Physical Involvement, Verbal Involvement, Responsiveness to Child, Play Interaction, Teaching Behavior, Control Activities, Directiveness/Demands, Relationship Among Activities, Positive Statements/Regard, Negative Statements/Regard, Goal Setting). Average ratings were then computed for the amount, quality, and appropriateness of the parent/caregiver

[c] Average for general impression ratings given above.

$$\hat{ES} = \frac{(\text{Center-Based + PIE Adj.}\bar{x}) - (\text{Center-based Adj.}\bar{x})}{\text{Center-Based (SD)}}$$

interests, responsivity, inventiveness in play, and effectiveness of parent to engage child in play interaction were summed and directiveness (frequency and intensity of directives) was subtracted. Factor 3, Performance Orientation, included achievement orientation, verbal praise, pace of parent's behaviors, and intensity and frequency of directives. The reliability coefficients of the three factors were .88, .83, and .61 respectively. The three factors were compared for the two groups at reassessments #1, #2, and #4. Covariates were included in the analyses when the correlation analyses indicated inclusion. The only statistically significant difference between groups was orientation to child's interests at reassessment #2 (see Table 9.16). Without somewhat congruent findings at reassessments #1 or #4, this difference appears likely to be due to chance.

Table 9.16

Comparison of Parental Behaviors as Coded by the PBRS (Mahoney) for the Parents in the Center-Based Only and Center-Based with Parent Involvement Groups for Reassessments #1, #2, and #4

		Center-based only				Center-based + PIE						
Variable	Covariates[1]	$\bar{x}$	(SD)	Adj.$\bar{x}$	n	$\bar{x}$	(SD)	Adj.x	n	ANCOVA F	p Value	ES
REASSESSMENT #1												
Affective relationship with child	1,2	14.5	(2.8)	14.4	26	15.5	(2.6)	15.6	19	2.22	.14	.43
Child orientation (responsivity to child)	0,2	14.2	(3.3)	14.3	26	15.1	(3.1)	14.9	20	.44	.51	.18
Performance orientation toward child	0	11.5	(2.9)	11.3	26	11.7	(3.2)	11.9	21	.47	.50	.21
REASSESSMENT #2												
Affective relation with child	1,2	14.4	(3.0)	14.2	19	15.1	(3.6)	15.3	15	1.33	.26	.37
Child orientation (responsivity to child)	0,2	13.8	(3.5)	13.7	19	15.3	(2.8)	15.5	16	3.13	.09	.51
Performance orientation toward child	0	11.4	(3.5)	11.4	19	10.7	(3.5)	10.7	16	.29	.59	-.20
REASSESSMENT #4												
Affective relationship with child	1,2	14.5	(2.6)	14.3	24	15.2	(2.6)	15.4	21	2.19	.15	.42
Child orientation (responsivity to child)	0,2	15.5	(3.6)	15.4	24	16.2	(2.1)	16.3	22	1.28	.26	.25
Performance Orientation toward child	0	9.3	(3.1)	9.2	24	9.4	(3.2)	9.5	23	.13	.72	.10

[1] Covariates: 0 = Battelle Total Raw Score at Assessment; 1 = FRS Total Score; 2 = PSI Total Score

$$\text{ES} = \frac{\text{Center-Based + PIE } \overline{\text{Adj.x}} - \text{Center-based } \overline{\text{Adj.x}}}{\text{Center-Based SD}}$$

__Parent-child interaction: High-attending analysis__. Comparisons of parent interactional behaviors and perceptions of family functioning were also performed with the high attending group and the center-based only groups. The parent/child interaction findings were mixed, depending on the rating system used (see Table 9.17). No group differences were found with the BPRS rating system, but the statistically significant differences found at reassessment #1 in the PCIS coding system variables, paralleled the group comparison findings (i.e., center-based only vs. center-based with parent involvement) (refer to Table 9.15). The statistical significance of these differences did not remain at reassessment #2. Possibly the content of the PIE instruction helped the parents in their interaction with their children for a short period of time.

Table 9.17

Comparison of Reassessment Measures of Parental Behaviors of Parents Who Attended 11 or More PIE Instruction Sessions, and Children of Parents in the Center-Based Only Group

		Center-based only				Attended 11 or more PIE Sessions						
Variable	Covariates*	$\bar{x}$	(SD)	Adj.$\bar{x}$*	n	$\bar{x}$	(SD)	Adj.$\bar{x}$*	n	ANCOVA F	p Value	ES
REASSESSMENT #1												
PCIS Average Rating (Farran)												
Amount		2.8	(.6)		26	2.6	(.5)		11	.37	.55	-.33
Quality	0	3.7	(.6)	3.7	26	4.3	(.6)	4.3	11	6.79	.01	1.00
Appropriateness	0	3.9	(.6)	3.9	26	4.4	(.7)	4.4	11	6.05	.02	.83
PBRS Factors (Mahoney)												
Affective Relationship	2,3	14.5	(2.8)	14.4	26	14.6	(2.8)	14.6	9	.04	.85	.07
Child Orientation	1,2	14.2	(3.3)	14.4	26	16.3	(3.3)	16.0	10	2.02	.17	.48
Performance Orientation	1	11.5	(2.9)	11.3	26	11.8	(3.5)	12.0	11	.49	.49	.24
REASSESSMENT #2												
PCIS Average Rating (Farran)												
Amount		3.0	(.6)		19	2.9	(.8)		9	.17	.68	-.17
Quality	0	3.9	(.9)	3.9	19	4.3	(.7)	4.3	9	1.51	.23	.44
Appropriateness	0	4.1	(.9)	4.1	19	4.4	(.6)	4.4	9	1.53	.23	.33
PBRS Factors (Mahoney)												
Affective Relationship	2,3	14.4	(3.0)	14.3	19	14.3	(3.7)	14.3	7	.00	.98	.00
Child Orientation	1,2	13.8	(3.5)	13.9	19	14.8	(2.7)	14.7	8	.46	.50	.23
Performance Orientation	1	11.4	(3.5)	11.4	19	10.0	(3.4)	10.1	8	.78	.39	-.37
REASSESSMENT #4												
PBRS Factors (Mahoney)												
Affective Relationship	2,3	14.5	(2.6)	14.3	24	15.1	(3.3)	15.2	10	.72	.40	.35
Child Orientation	1,2	15.5	(3.6)	15.6	24	15.9	(2.0)	15.8	11	.06	.81	.06
Performance Orientation	1	9.3	(3.1)	9.2	24	9.1	(3.7)	9.2	12	.00	.95	.00

* Covariance adjusted means

* Covariates: 0 = # of Siblings in Family; 1 = Battelle Total Raw Score at Assessment; 2 = PSI Total; 3 = FRS Total

$$\hat{\ } \quad ES = \frac{\text{Center-Based + PIE Adj.}\bar{x} - \text{Center-based Adj.}\bar{x}}{\text{Center-Based SD}}$$

Two-way analysis of variance. A series of 2-way analysis of variance comparisons were completed using the group assignment as a factor at either of two levels of income, gender, developmental quotient, or parental knowledge of behavioral principles. Dependent variables included child developmental measures on the subscales of the Battelle Developmental Inventory (see Table 9.18). Dividing the sample into dichotomous groups along two dimensions allowed analysis of four cells and provided a method of checking for significant interactions of child development among the defined independent variables.

Using the center-based only or center-based plus parental involvement group as one factor and the level of income ,divided at the median level of $22,535 per year at pretest, revealed that child development did not differ as a function of family income There were also no group differences initially, but several emerged in post assessments #2, #3 and #4. It seems that children who were in families that made less than $22,535

Table 9.18

Two-Way Analysis of Variance for Child Outcomes at the Utah Parent Involvement Study

	Battelle Total at Assessment									
	df	Initial	df	1	df	2	df	3	df	4
Income (I)	1	.03	1	.38	1	.34	1	.15	1	.00
Group (G)	1	.23	1	1.39	1	3.01*	1	4.94*	1	4.29**
Income X Group	1	.01	1	.14	1	2.36	1	1.23	1	1.84
Error	52	(6589)	52	(7803)	36	(5452)	47	(9274)	48	(12249)
Gender (S)	1	.20	1	.18	1	.00	1	.07	1	.13
Group (G)	1	.18	1	.133	1	3.68*	1	5.09**	1	4.31**
Gender X Group	1	.99	1	2.29	1	9.98**	1	3.26*	1	4.54**
Error	52	(6446)	52	(7524)	36	(4589)	47	(8912)	48	(11590)
DQ 65 (65)	1	12.22***	1	19.62***	1	19.31***	1	24.20***	1	29.47***
Group (G)	1	.00	1	.48	1	2.80	1	2.26	1	1.83
65 X Group	1	.40	1	.67	1	2.19	1	.88	1	1.05
Error	52	(5306)	52	(5669)	36	(3670)	47	(6224)	48	(7775)
DQ < 58 (58)	1	14.79***	1	22.86***	1	18.18***	1	30.02***	1	39.46***
Group (G)	1	.00	1	.55	1	2.73	1	3.35*	1	3.04*
58 X Group	1	.03	1	.15	1	.00	1	.01	1	.07
Error	52	(5312)	52	(5463)	36	(3894)	47	(5824)	48	(6975)
Parental Knowledge (K)									1	.41
Group (G)									1	4.65**
Knowledge X Group									1	.78
Error									48	(12410)

* .10
** .05
*** .001
NOTE: Values enclosed in parenthesis represent mean square errors.

at preassessment and were in the center-based only group obtained significantly (ranging from $F = 4.29$, $p < .05$ for BDI total score at reassessment #4 to $F = 6.15$ $p < .02$ for BDI communication score at reassessment #3) lower scores than the poorer children who were in the center-based plus parent involvement group. Group differences among those families who made more than $22,535 per year were non-significant across post assessments and across BDI scores.

Group differences again emerged at the later reassessments using gender as the other independent variable, and throughout reassessments significant interactions between gender and groups appeared on child development measures. Males in the center-based only group consistently scored significantly ($p < .05$) lower on the BDI than males in the center-based plus parental involvement group. These differences emerged in the communication subscale at reassessments #2 and #3 on the total score at reassessments 3 and 4. These significant differences were generally compounded by significant interaction effects showing female center-based plus parent involvement group children outscoring their center-based only group counterparts; though not significantly.

Subdividing the subjects into their respective groups according to their computed developmental quotient [(age equivalent scores ÷ chronological age) X 100] of course found significant differences between the high scoring children and the low scoring children. However, there were no primary group differences ($p < .05$). The center-based plus parental involvement group children who had an initially higher developmental quotient (analysis run with DQ > 65) did not differ significantly from the center-based only group children who had an initially higher developmental quotient. Analysis completed using the DQ dividing line of 58 showed a significant difference between the groups on the BDI total score and reassessments #3 and #4. Further analysis revealed that those who were in the high-functioning group and in the center-based plus parent-involvement group made small but statistically significant ($p < .10$) gain over their high-functioning center-based only group counterparts. These findings lend support to the idea that parent involvement was not more beneficial for children with mild disabilities but may have been more beneficial for children with severe disabilities.

The present teachers' ratings of parents, used as an independent variable along with the group category, showed a consistent finding on the BDI total score. At reassessment #4, among children whose parents were rated as having less knowledge, the center-based plus parental involvement group scored significantly higher on the BDI ($p < .05$) than their center-based only group counterparts (mean = 524 and 431, respectively). Likewise, when the groups were divided into low and high groups, as defined by the teachers' ratings of support, those parents who were rated as more supportive and were in the center-based plus parent involvement program fared significantly better on the BDI than the more supportive parents in the center-based only group. The children in the parental involvement group, whose parents the teachers rated high on attendance, also received higher scores on the BDI. Despite the fact, there were significant group differences (center-based with parent involvement versus center-based only) on the total score of the BDI at reassessment #4 ($p < .05$) without partitioning the cells by the teacher's rating of the parents (see Table 9.10), the additional division provided insight. For example, these results provide limited evidence of the differential impact of the parent involvement component on subsequent teacher evaluations of the parent. Parents who received the parent involvement component of the early intervention and who were rated low on the parent knowledge scale had children who scored statistically significantly higher than parents who did not have the participation component and were rated as less knowledgeable. There also appeared to be higher functioning children in the center-based plus parent involvement group as differentiated by the teachers rating of support. These analysis, while inconclusive, bear further investigation and explanation.

In sum, those parents whom the teachers rated as involved and were in the parent involvement group had children who generally scored higher on the BDI (the mean BDI score for low knowledge scoring parent group, as perceived by the teachers, being the exception). Longitudinal parental involvement, as perceived by children's teachers, seems to be related to the children's subsequent development.

In summary, partitioning the cells into finer subgroups for analysis yielded few significant results. Income was not a significant factor for finding overall group differences. Likewise, dividing the children along dimensions of their computed developmental quotient provided few significant results. However, using gender as an independent variable showed parental involvement may have more of an effect on males than females. These analyses were complicated by significant interaction however, and need to be interpreted with caution. Further analysis of teachers' ratings of parental knowledge, support and attendance showed a few consistent results that warrant further study and analysis. With few exceptions (the ratings of parental knowledge being primary), children in the parent involvement group whose parents the teachers perceived as more involved scored significantly higher on the BDI. The 2-way ANOVAs provided a few significant results, and allowed analysis at a finer level.

Conclusions and Discussion

The primary purpose of this investigation was to ascertain the immediate and long-term effects on children with disabilities and on their families of the addition of a particular parent involvement program to a center-based early intervention program. In order to do so, two groups of parents and their children with disabilities were randomly assigned to one of two groups. All children attended a center-based early intervention program. The parents of half of the children participated in a parent involvement program. In this parent involvement program, the parents were taught to provide therapeutic intervention services for their children and to be more effective partners in the intervention process. The parent involvement sessions also offered the parents an opportunity to form support networks with each other and discuss concerns.

This longitudinal study was methodologically sound with random assignment to treatment, treatment verification measures, multiple child and family measures, and "blind" assessment at all reassessments.

The cost for the additional intervention was minimal for the agency. Most of the cost was in terms of time costs for the parents. Nevertheless, in evaluating the cost-effectiveness of this particular intervention, the moderate costs must be considered.

In interpreting the longitudinal findings, it must be remembered that the randomly selected groups were well-matched on demographic, child, and family measures when the study began. The analyses of intervening contextual variables revealed no significant group differences on intervening demographic or family measures, or additional services, thus controlling, for historical threats to the research findings.

Parents were the ones actually involved in the additional intervention. Influencing parent behaviors, abilities, and attitudes were goals of the intervention. Parental changes in these areas were, in turn, to affect changes (i.e., improvement) in child development. Parent and family effects are, therefore, discussed first, followed by child effects. Specifically, we investigated whether the parent involvement program influenced (a) perceived social support, (b) parenting stress, (c) family functioning, (d) participation in the child's education, and (e) the parent and child interactions.

Family Benefits

The measure of social support showed the same trend of significant differences favoring the parents in the parent involvement groups at the first reassessment but not at later reassessments. These results are logical. The parents reported more social support when they were involved with the social worker and other parents in the group, but not after the parent involvement classes ended.

Likewise, the parents in the center-based with parent involvement group reported statistically significantly higher levels of family cohesion than did the other parents at reassessments #1 and #2, but not at later reassessments. The group difference was greater at the first reassessment than at the second. We have difficulty interpreting the family cohesion score differences. Perhaps attending the class encouraged perceptions of family cohesion, but usually only one parent (the mother) attended the classes, and none of the curricula seemed to target family cohesion per se. If there is a generalized indirect effect on family cohesion, it seems likely that there might also have been one on family adaptability, but there was not. However, others have found the adaptability portion of the FACES III scale problematic (Ben-David, 1991; Green, 1991).

The later measures of family functioning, the Family APGAR, and the Family Functioning Style Scale, provided a few consistent results. These measures were taken four to eight years after the intervention ended, seven and eight years after the intervention, families in the center-based plus parent involvement group reported that they engaged in more information sharing than families in the center-based only group. This is consistent with the cohesion results and provides evidence of an increased amount of communication over time. The Family APGAR did not provide consistent results from one year to the next.

The parent involvement program appears to have had no effect on parent stress as measured by the PSI or the mother's depression as measured by the CES-D at the first reassessment. However, many of the items in the PSI scale that measure the parent's perception of what the child brings to the parent-child relationship (child stress domain) appear to deal with characteristics common to all children with disabilities (Innocenti, Huh, & Boyce, 1991), and might not be amenable to change, regardless of the type of intervention program. The parent domain of stress (i.e., the other relationships in a parent's life that parenting this particular child might impact) appears to be more related to other contextual aspects of the parent's life (e.g., perceptions of resources, support, other life stressors, and family cohesion than it is to any child characteristics (Boyce, Behl, Mortensen, & Akers, 1991). These other aspects of a parent's life (e.g., family resources, stressful life events), with the exception of the provision of social support, might not easily be affected by this type of group involvement program.

To understand how the parents perceived the involvement program, they were interviewed at the second assessment concerning the program (refer to Treatment Verification section). Seventeen of the 20 parents in the parent involvement group who participated in the second assessment were interviewed. The majority reported less stress or no change in stress in their lives after the instruction. Fourteen of the 17 parents reported that they felt the PIE program positively influenced their interactions with their children, with these parents claiming greater objectivity and more effective use of reward and punishment. While there is no psychometric measure of validity or reliability for these interviews with parents who participated in the parent involvement component, these findings are interesting. Albeit their answers may have been influenced by their desire to give the "socially appropriate" answer, their perception of positive influence on their interaction with their children corroborates our findings of differences in quality of parent interactional behavior. That most parents reported experiencing less stress after the classes were completed suggests that the involvement program alleviated parents' perception of stress, but not in a way that was measured by the PSI or the CES-D.

Beneficial effects on parents' attitudes toward, and their participation in their child's educational program could also be expected from a program which taught parents to be effective partners in intervention. The two groups varied statistically significantly when rated by their children's later school teachers at reassessment #4. The parents in the parent involvement program were judged to be more knowledgeable, supportive, and attend more of the educational meetings than did the parents in the center-based only group. However, these findings were not replicated at reassessments #5, #6, #7, or #8. The questionnaire was revised after reassessments #4; the difference in questionnaires might account for the findings not being replicated. The finding that the parents who attended the parent involvement sessions frequently (i.e. the high attending group in the participation comparison analysis) were consistently considered more knowledgeable and more supportive of their children's education than those parents who were not invited to the sessions suggests that there may have been some long-range effects from participation in the parent classes. This question of whether parent involvement group participation affects the efficacy of later parental participation in their children's education needs further investigation.

Parent interactional behaviors were measured by two rating systems; the PCIS rating scale (Farran et al., 1986) and the PBRS (Mahoney, 1988). Only one statistically significant difference at one reassessment was found on the PCIS. This was likely due to chance. The effect sizes, although large, are likely inflated because of the Likert form of scaling. The PBRS provided similar results. Differences were not found between the two groups' interactional behaviors at any of the three reassessments. Involvement in the PIE program with the discussions of child growth and development and information as to how to provide intervention to their children may have influenced the parental behaviors but the interactions were not noted in the coding systems.

Child Benefits

Benefits in child development were the primary desired outcomes. Advantages for the children of the parents participating in the program was not apparent at the first assessment, but some benefits were found at the second assessment. With the parents just completing the classes at the first assessment, it is questionable whether enough time had lapsed for any new parental behaviors, attitudes, etc., to impact child development. Maybe a certain amount of time is needed for any parenting changes to affect child changes. The subsequent reassessments showed consistent and statistically significant benefits for the children in the center-based plus parent involvement group. From reassessments #2 through #4 those children scored higher on the BDI total score than the center-based only group. The effect sizes also increased with each succeeding year. The Skills Knowledge score of the WJ-R also showed statistically significant benefits for the center-based plus parent involvement group children from reassessments #5 through #8. As the children's scores on the developmental measures were comparable at both the initial assessment and at reassessment #1, and methodologically sound research was completed, a marked increase in the developmental scores of children in the center-based plus parent involvement group appears to be the result of the intervention.

These results are further collaborated by the children's parent's and teachers. From reassessment #6 through #8 the children's school teachers consistently reported that children who were in the center-based plus parent involvement group consistently showed fewer problem behaviors than children in the center-based only group. At reassessment #6 the parents agreed. At reassessments #7 and #8 the teachers also reported the children in the center-based plus parent involvement group showed more socially appropriate behavior.

The same analyses were completed for the center-based only group and a group of children whose parents regularly attended the parent involvement meeting. The same general results were obtained, except at a higher effect size magnitude. Conclusions about the relationship between the number of sessions attended and later development can not be drawn at this time, but it is apparent that the intervention had some effect on subsequent child development.

Implications

The research with typically developing children continues to demonstrate that parent knowledge makes a small, but significant contribution to a child's development (cf., Dichtelmiller et al., 1992, for a review of this literature). Research with a sample of 40 extremely low birthweight infants (less than 1250 g) also revealed that mother's knowledge contributed to child development (Dichtelmiller et al., 1992). It can be concluded from this type of research that changing parents attitudes and beliefs is a logical way to affect child developmental outcomes.

However, much remains to be learned about the best ways and under what conditions parent instruction and other parent involvement programs will benefit children with disabilities and their families. Over the last two decades, the benefits and inadequacies of parent involvement programs, and in particular, parent group instruction programs have been hotly debated on both practical and theoretical levels.

On a theoretical level, some authorities have expected a "snowball" effect. They propose that if parents gained experience in providing intervention in building proactive relationships early in their children's lives, these effects would "snowball" and result in more supportive home environments and more effective home-school linkages (cf., Zigler, Taussig, & Black, 1992).

Others have questioned the long-term benefits of an "inoculation model", described as a brief intervention. They assert that a "single dose" of any program cannot reap long term benefits and that a fade-out of effects over time should be expected (cf., Zigler et al., 1992). Most parent instruction programs fit this description in that they include approximately 16 to 20 hours of instruction (e.g., Baker, 1989).

The appropriate content for the instruction has also been debated. Recently, experts started calling for programs that focus on parental support and parent empowerment rather than on programs focused on teaching parents intervention skills (e.g., Guralnick, 1993). In the midst of these discussions, the parent's voice has been heard. Recent surveys of parents of children with disabilities reveal that parents continue to want information on dealing with their children. Upshur (1991) found that although group meetings were not the most preferred service delivery format, mothers and fathers reported that learning to work with their child was the program area that was the most beneficial. Gowen, Christy, and Sparling (1993) also reported from their national survey that the major need expressed by parents was for information on how to promote development of their children with special needs.

In interpreting the results of the present study it is important to consider the above issues. This study cannot answer all of the questions posed (and no single study could), but it provides important information regarding these issues. The central issue is "Did this instructional type of parent involvement work? Were there benefits? Were the benefits derived cost effective?

In his monograph on parent training with families of children who have developmental disabilities, Baker (1992) proposed the following criteria for evaluating parent training programs:

1. SOCIAL VALIDITY: Do parents find the goals and the methods of the program worthwhile?
2. ENROLLMENT: Do parents enroll in the program?
3. COMPLETION: Do parents maintain good attendance?
4. PARTICIPATION: Do parents learn what the program aims to teach?
5. CONSUMER SATISFACTION: Do parents express satisfaction with the program?
6. PROFICIENCY: Do parents learn what the program aims to teach?
7. CHILD GAINS: Do children show demonstrable gains?
8. MAINTENANCE OF CHILD GAINS: Do child gains last?
9. MAINTENANCE OF TEACHING: Do parents continue to put what they learned into practice at home months or years later?
10. FAMILY BENEFITS: Do parents' attitudes or family adjustment (e.g., stress, coping, parent-child relationship) change?
11. ADVOCACY: Do parents become better advocates for their child's education? (p. 12)

The research design of the present study allows us to address questions 1, 3, 5, 6, 7, 8, 10, and 11. The findings of the study in relation to each of these questions are discussed in the following.

1. Social validity. Did the parents find the goals and methods of the program worthwhile? The parent interview at Reassessment #2 addresses this issue. The parents who had participated in the parent instruction classes reported that the program had positively influenced their interactions with their

children (82%). They reported greater objectivity and more effective use of reward and punishment.

3. Completion. Did parent maintain good attendance? Attendance varied. Parents, on the average, attended nine (58%) of the 15 sessions.

5. Consumer Satisfaction. Did the parents express satisfaction with the program? The interviews at Reassessment #2 found that eighty-eight percent of the parents reported satisfaction with the classes and assignments.

6. Proficiency. Did the parents learn what the program taught? The test of parent's knowledge, based on the class curriculum, was administered three times (Reassessment #1, #2, and #4). Each time the parents in the parent involvement group scored higher than the parents in the center-based only group. At the first two reassessments the difference were statistically significant.

7. Child Gains. Did the children show demonstrable gains? Yes. In the second through eighth years after the conclusion of the parent involvement program the children in the parent involvement group scored statistically significantly better on the measures of child development than the children in the center-based only group. Subsequent differences in social skills were found at other reassessments with children in the parent-involvement group being rated by their parents or teachers as having fewer behavioral problems.

8. Maintenance of Child Gains. An advantage for the children in the parent involvement group was found on the BDI at reassessments 2, 3, and 4. Likewise, they maintained an advantage on skills knowledge, and sometimes broad knowledge, as measured by the achievement test (WJ-R), over reassessments #5, 6, and 7.

10. Family Benefits. Did the parents' attitudes or family adjustment change? We have not analyzed change over time of parent attitudes and adjustments, but we compared the parent social support, stress, adaptability and cohesion of the parents in the center-based and the center-based with parent involvement groups. Parents in the parent involvement group reported more social support and more family cohesion at the end of the involvement program classes, but across later reassessments. Reported parenting stress was similar for both groups at all reassessments.

11. Advocacy. Did parents become better advocates for their children's education? Two types of analyses provide us with information about later advocacy. The comparison of those parents who attended the parent involvement classes frequently (participation comparison) revealed that those high attending parents were later judged by their children's teachers as being statistically significantly more knowledgeable and more supportive of their children's education. Second, the regression analyses examining the predictors of parent support and knowledge for their children's education indicated that higher scores on the parent test of behavioral principles predicted later higher ratings of support and knowledge.

Two replications of this study (Boyce, White, & Kerr, 1993; Innocenti, Hollinger, Escobar, & White, 1993) reported fewer advantages for children or families of those parents who participated in the parent involvement intervention program. Some analyses across the three sites have been completed (e.g., Innocenti, Huh, & Boyce, 1993), but more research needs to be done. All of the criteria discussed above were not completely satisfied. Yet the intervention was expensive primarily in terms of parent time, not in costs to the agency. Therefore, it seems that a number of benefits were gained from this easily administered, relatively inexpensive program of a short duration. However, two replications of this study (Boyce, White, & Kerr, 1993; Innocenti, Hollinger, Escobar, & White, 1993) reported fewer advantages for children or families of those parents who participated in the parent involvement intervention program. Some analyses across the three sites have been completed (e.g., Innocenti, Huh, & Boyce, 1993), but more needs to be done.

REFERENCES

Abidin, R. R. (1986). Parenting stress index-manual. Charlottesville, VA: Pediatric Psychology Press.

Abidin, R. R. (1990). Parenting stress index-short form. Charlottesville, VA: Pediatric Psychology Press.

Achenbach, T. M. (1986). Manual for the Child Behavior Checklist and Revised Child Behavior Profile. Burlington: Department of Psychiatry, University of Vermont.

Achenbach, T. M., & Edelbrock, C. S. (1986). Child behavior checklist. Burlinotn, VT: Author.

Achenbach, T. M., & Edelbrock, C. S. (1986). Teacher's report form. Burlington, VT: Author.

Achenbach, T. M., Phares, V., Howell, C. T., Rauh, V. A., & Nurcombe, B. (1990). Seven-year outcome of the Vermont intervention program for low birthweight infants. Child Development, 61, 1672-1681.

Adelson, E., & Fraiberg, S. (1974). Child development project. Child Development, 45, 114-126.

Allegheny County Schools (1969). A demonstration project on developing independence in preschool handicapped children. Pittsburgh, PA: Author. (ERIC Document Reproduction Service No. ED 032 699)

Alpern, G., Boll, T., & Shearer, M. (1980). Developmental Profile II. Los Angeles: Western Psychological Services.

Als, H. (1983). Assessment, intervention and remediation: The study of the development of a blind infant in interaction with her mother. In M. Wurster, & M. E. Mulholland (Eds.), Help me become everything I can be. Proceedings of the North American Conference on Visually Handicapped Infants and Young Children, New York: American Foundation for the Blind.

Bagnato, S. J., & Neisworth, J. T. (1989). Perceptions on developmental status. Circle Pines, MN: American Guidance Service.

Bagnato, S. J., Jr., & Neisworth, J. T. (1980). The intervention efficiency index: An approach to preschool program accountability. Exceptional Children, 46, 264-269.

Bailey, E. J., & Bricker, D. (1984). The efficacy of early intervention for severly handicapped infants and young children. Topics in Early Childhood Special Education, 4, 30-51.

Bailey, D. B., & Simeonsson, R. J. (1988). Home-based early intervention. In S. J. Odom, & M. B. Karnes (Eds.), Early intervention for infants and children with handicaps. Baltimore, MD: Brookes Publishing.

Baker, B. L. (1989). Parent training and developmental disabilities. Monographs of the American Association on Mental Retardation, 13.

Baker, B. L., & McCurry, M. C. (1984). School-based parent training: An alternative for parents predicted to demonstrate low teaching proficency following group training. *Education and Training of the Mentally Retarded*, *7*, 261-268.

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

Barnett, W. S. (1986). Methodological issues in economic evaluation of early intervention programs. *Early Childhood Research Quarterly*, *1*.

Barnett, W. S., & Escobar, C. M. (1987). The economics of early educational intervention: A review. *Review of Educational Research*, *57*, 387-414.

Barnett, W. S., Escobar, C. M., & Ravsten, M. (1988). Parent and clinic early intervention for children with language handicaps: A cost-effectiveness analysis. *Journal of the Division for Early Childhood*, *12*, 12-24.

Barnett, W. S., & Pezzino, J. (1987). Cost-effectiveness analysis for state and local decision making: An application to half-day and full-day preschool special education programs. *Journal of the Division for Early Childhood*, *11*, 171-179.

Barraga, N. C. (1986). Sensory perceptual development. In G. T. School (Ed.), *Foundation of education for blind and visually handicapped children and youth*. New York: American Foundation for the Blind.

Barrera, M. E., Cunningham, C. E., & Rosenbaum, P. L. (1986). Low birth weight and home intervention strategies: Preterm infants. *Developmental Behavior Pediatrics*, *7*, 361-366.

Bayley, N. (1969). *Bayley Scales of Infant Development*. New York: The Psychological Corporation.

Bayley, N. (1970). Development of mental abilities. In P. H. Mussen (Ed.), *Carmichael's manual of child psychology* (Vol. I, 3rd ed.). New York: Wiley.

Beery, K. E. (1989). *The Developmental Test of Visual-Motor Integration: Administration, Scoring, and Teaching Manual* (3rd REvision). Cleveland, OH: Modern Curriculum Press.

Bennett, F. C. (1987). *The effectiveness of early intervention for at-risk and handicapped children*. New York: Academic.

Berrueta-Clement, J. R., Schweinhart, L. J., Barnett, W. S., Epstein, A. S., & Weikart, D. P. (1984). *Changed lives: The effects of the Perry Preschool Program on youths through age 19*. Ypsilanti, MI: High/Scope Press.

Blacker, J. (1984). A dynamic perspective on the impact of a severley handicapped child on the family. In J. Blacker (Ed.), *Severely handicapped young children and their families: Research in review*, (pp. 3-50). Orlando, FL: Academic, Inc.

Blank, M., & Solomon, F. (1968). A tutorial language program to develop abstract thinking in socially disadvantaged preschool children. *Child Development*, *39*, 379-389.

Blasco, P. M., Hrncir, E. J., & Blasco, P. A. (1990). The contribution of maternal involvement to mastery performance in infants with cerebral palsy. *Journal of Early Intervention*, *14*, 161-174.

Boehm, A. (1971). *Boehm Test of Basic Concepts*. San Antonio, TX: The Psychological Corporation.

Bowerman, R. A., Donn, S. M., Silverman, T. M., & Joffe, M. H. (1984). Natural history of neonatal periventricular/intraventricular hemorrhage and its complications: Sonographic observations. *American Journal of Roentgenography*, *143*, 1041-1052.

Boyce, G. C., & Barnett, W. S. (1991, September). *Parenting children with Down syndrome: Do your activities and attitudes differ from parents of children without Down syndrome*? Paper presented at the 19th Annual Convention of the Naitonal Down Syndrome Congress, Boston, MA.

Boyd, R. D., Welge, P., Sexton, D., & Miller, J. H. (1989). Concurrent validity of the Battelle Developmental Inventory: Relationship with the Bayley Scales in young children with known or suspected disabilities. *Journal of Early Intervention*, *13*, 14-23.

Boyce, G. C. (1993). Utah parent involvement study. In K. R. White (Ed.), *1991-92 annual report of the longitudinal studies of the effect of early intervention intervention for children with disabilities* (contract # HS90010001). Early Intervention Research Institute, Utah State University, Logan.

Boyce, G. C., White, K. R., & Kerr, B. (1993). The effectiveness of adding a parent involvement component to an existing center-based program for children with disabiltiies and their families. *Early Education and Development*, *4*(4).

Bozynsky, M. E. A., Nelson, M. N., Rosati-Skertich, C., Genaze, D., O'Donnell, K., & Naughton, P. (1984). Two year longitudinal followup of premature infants weighing ≤ 1200 grams at birth: Sequelae of intracranial hemorrhage. *Developmental and Behavioral Pediatrics*, *5*, 346-352.

Bregani, P., Cepellini, C., Cerebalini, R., Contini, G., Damascelli, A., Livingstone, J. B., Premoli, M., & Rocca, A. (1981). Blind children: Prevention of emotional disturbances by early intervention with parents and child. *Courier*, *31*, 256-262.

Bricker, D. D. (1986). *Early education of at-risk and handicapped infants, toddlers, and preschool children*. Glenview, IL: Foresman and Co.

Bricker, D., Bailey, & Bruder, M. (1984). The efficacy of early intervention and the handicapped infant: A wise or wasted resource. In R. Wolriach & D. Routh (Eds.), *Advances in developmental and behavioral pediatrics: A research annual* (Vol. 5, pp. 373-423). Greenwich, CT: JAI Press.

Bricker, D., & Slentz, K. (1988). Personnel preparation: Handicapped infants. In M. C. Wang, M. C. Reynolds, & H. J. Walberg (Eds.), *Handbook of special education: Research and practice (Vol. 3): Low incidence conditions*. Oxford, England: Pergamon Press.

Bronfenbrenner, U. (1974). *A report on longitudinal evaluations of preschool programs. Volume II: Is early intervention effective*? (ERIC Document Reproduction Services Number ED093 501)

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*, 513-531.

Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press.

Brooks-Gunn, J., Klebanov, P. K., Liaw, F., & Spiker, D. (1993). Enhancing the development of low-birthweight, premature infants: Changes in cognition and behavior over the first three years. Child Development, 64, 736-753.

Brooks-Gunn, J., Liaw, I., & Klebanov, P. K. (1992). Effects of early intervention on cognitive function of low birth weight preterm infants. The Journal of Pediatrics, 120, 350-359.

Brown, S. L., D'Eugenio, B. D., Drews, J., Hasikin, B. S., Whiteside, Lynch, E., Moersch, M., & Rogers, S. (1981). Early Intervention Developmental Profile. Ann Arbor: University of Michigan Press.

Bruder, M. B., & McLean, M. (1988). Personnel preparation for infant interventionists: A review of federally funded projects. Journal of the Division for Early Childhood Education, 12, 299-305.

Bruininks, Woodcock, Weatherman, & Hill (1984). Scales of independent behavior. Allen, TX: DLM Teaching Resources.

Bryant, D. M., & Ramey, C. T. (1987). An analysis of the effectiveness of early intervention for environmentally at-risk children. In M. J. Guralnick & F. C. Bennett (Eds.), The Effectiveness of Early Intervention for At-Risk and Handicapped Children (pp. 33-78). Orlando, FL: Academic Press.

Burkett, C. W. (1982). Effects of frequency of home visits on achievement of preschool students in a home-based early childhood education program. Journal of Educational Research, 76, 41-44.

C.H.A.D.D. National Educational Committee (1992). Association for Children with Attention defecit disorders Educational Manual. Fairfax, VA: CASET Associates, Ltd.

Carran, N. M (1983). Continuum of assessment programming evaluation and resources. University of North Carolina at Chapel Hill, Western Hills Area Education Agency.

Carta, J. J., Greenwood, C. R., & Atwater, J. B. (1986). Ecobehavioral system for the complex assessments of preschool environments. Kansas City, KY: Juniper Gardens Children's Project.

Carta, J. J., Sainato, D. M., & Greenwood, C. R. (1988). Advances in the ecological assessment of classroom instruction for young children with handicaps. In S. L. Odom, & M. B. Karnes (Eds.), Early intervention for infants and children with handicaps, (pp. 217-240). Baltimore, MD: Paul H. Brookes.

Casto, G. (Ed.) (1979). Curriculum and monitoring system. New York: Walker Publishing.

Casto, G. (1987). Plasticity and the handicapped child: A review of efficacy research. In J. J. Gallagher & C. T. Ramey (Eds.), The malleability of children, (pp. 103-113). Baltimore, MD: Brookes Publishing.

Casto, G., Gaynard, L., Mobasher, H., Chan, G., Dolcourt, J., Levkoff, A., & Saylor, C. (1987). The efficacy of early intervention programs for low birth weight infants. In G. Casto, F. Ascoine, & M. Salehi (Eds.), *Current perspectives in infancy and early childhood research (vol.1, pp. 23-31)*. Logan, UT: Early Intervention Research Press.

Casto, G., & Lewis, A. (1984). Parent involvement in infant and preschool programs. *Journal of the Division for Early Childhood*, *9*, 49-56.

Casto, G., & Mastropieri, M. A. (1986). The efficacy of early intervention programs: A meta-analysis. *Exceptional Children*, *52*, 417-424.

Casto, G., White, K. R., & Taylor, C. (1983). *Final report 1982-83 work scope*. Logan, UT: Early Intervention Research Institute, Utah State University.

Caton, H. R. (1976). *The Tactile Test of BAsic Concepts*. Louisville, KY: American Printing House for the Blind.

Cicirelli, V. G. (June, 1969). *The impact of Head Start: An evaluation of the effects of Head Start on children's cognitive and affective development*. Washington, DC: National Bureau of Standards, Institute for Applied Technology.

Clarke-Stewart, K. A. (1982). Exploring the assumptions of parent education. In R. Haskins (Ed.), *Parent education and public policy*, (pp. 257-271). Norwood, NJ: Ablex Publishing Co.

Clarke-Stewart, K. A., & Apfel, N. (1978). Evaluating parental effects on child development. *Review of Research in Education*, *6*, 47-117.

Cohen, J. (1977). *Statistical power analysis for the behavioral sciences*. New York: Academic Press.

Cohen, J. (1990). Things I have learned (so far). *American Psychologist*, *45*, 1304-1312.

Comptroller General. (1979). *Early childhood and family develpment programs improve the quality of life for low income families*. Report to the Congress of the United States.

Cooke, T. J., & Poole, W. K. (1982). Treatment implementation and statistical power. *Evaluation Review*, *6*, 425-430.

Cooper, D. H., & Farran, D. C. (1988). *The Cooper-Farran behavior rating scale*. Greensboro, KY: University of North Carolina.

Cornell, E. H., & Gottfriend, A. W. (1976). Intervention with premature human infants. *Child Development*, *47*, 32-39.

Correa, V. I., Poulson, C. L., & Salzberg, C. (1984). Training and generalization on reach-grasp behavior in blind, retarded young children. *Journal of Applied Behavior Analysis*, *17*, 57-69.

Council for Exceptional Children (1993). *DEC recommended practices: Indicators of quality in programs for infants and young children with special needs and their families*. Reston, VA: Author.

Datta, L. (1971). A report on evaluation studies of Project Head Start. International Journal of Early Childhood, 3, 58-69.

Denzin, N. K. (1978). The research act: A theoretical introduction to sociological methods (2nd ed.). Chicago: Adline Press.

DeStefano, D. M., Howe, A. G., Horn, & E. M., & Smith, B. A. (1991). Best practices: Evaluating early childhood special education programs. Tucson, AZ: Communication Skills Builders, Inc.

Devillis, R. F., Revicki, D. A., & Bristol, M. M. (1985). Development of the Child Improvement Locus of Control (CILC) Scales. Unpublished manuscript, University of North Carolina at Chapel Hill.

Dichtelmiller, Meisels, Plunkett, Bozynski, Claflin, & Mangeldorf (1992).

Dunn, L. M., & Dunn, L. M. (1981). The Peabody Picture Vocabulary Test--Revised. Circle Pines, MN: American Guidance Service.

Dunst, C. J. (1986). Overview of the efficacy of early intervention programs. In L. Bickman, & D. L. Weatherford (Eds.), Evaluating early intervention programs for severely handicapped children and their families, (pp. 79-147). Austin, TX: Pro Ed.

Dunst, C. J., Jenkins, V., & Trivette, C. M. (1984). The family support scale: Reliability and validity. Journal of Individual, Family, and Community Wellness, 1, 45-52.

Dunst, C. J., & Leet, H. E. (1985). Family Resource Scale. Morganton, NC: Western Carolina Center.

Dunst, C. J., & Rheingrover, R. M. (1981). An analysis of the efficacy of infant intervention program with organically handicapped children. Evaluation and Program Planning, 4, 287-323.

Dunst, C. J., Snyder, S. W., & Mankinen, M. (1989). Efficacy of early intervention. In M. C. Wang, M. C. Reynolds, & H. J. Walberg (Eds.), Handbook of Special Education, 3, 259-294.

Dunst, C. J., Trivette, C. M., & Deal, . (1988). A family systems model of early intervention with handicapped and developmentally at-risk children. In D. R. Powell (Ed.), Parent education as early childhood intervention: Emerging directions in theory, research, and practice. Norwood, NJ: Ablex Publishing.

Durbala, L., & Hollinger, P. (1988). Parents involved in education--II. Early Intervention Research Institute, Utah State University, Logan.

Early Intervention Research Institute (1988). Treatment Verification Handbook. Logan, UT: Author.

Ellison, P. H., Horn, J. L., & Browning, C. A. (1985). Construction of an infant neuroloigcal international battery (INFANIB) for the assessment of neurological integrity in infants. Physical Therapy, 65, 7.

Escobedo, M. B., Gonzalez, A. (1986). Bronchopulmonary dysplasia in the tiny infant. Clinics in Perinatology, 13, 315-326.

Falvo, D. R. (1985). Effective patient education: A guide to increasing compliance. Rockville, MD: Aspen Publishers, Inc.

Farran, D. C. (1990). Effects of intervention with disadvantaged and disabled children: A decade review. In S. J. Meisels & J. P. Shonkoff (Eds.), Handbook of early childhood intervention (pp. 501-539). New York: Cambridge University Press.

Farran, D. C., Kasari, C., Comfort, M., & Jay, S. (1986). Parent/caregiver involvement scale. (Revision of Parent-Child Interaction Scale, 1980, 1981, 1984). Available from D. C. Farren, Center for Development of Early Education, Kamehameha Schools/Bishop Estate, Honolulu, HI 96817.

Ferrell, K. A. (1986). Reach out and teach. Teacher's manual. New York: American Foundation for the Blind.

Ferrell, K. A. (1990). (Personal Communication).

Fewell, R. R. (1986). Play assessment Scale (fifth revision). University of Washington, Seattle.

Field, T. M., Widmayer, S. M., Stringer, S., & Ignatoff, E. (1980). Teenage, lower class, black mothers and their preterm infants: An intervention and developmental follow-up. Child Development, 51, 426-436.

Florin, P. R., & Dokecki, P. R. (1983). Changing families through parent and family education: Review and analysis. In I. Sigel, & L. L. Laosa (Eds.), Changing families, (pp. 23-61). New York: Plenum Press.

Foster, M., Berger, M., & McLean, M. (1981). Rethinking a good idea: A reassessment of parent involvement. Topics in Early Childhood Special Education, 1, 55-65.

Foster, G., Ysseldyke, J., & Reese, J. (1975). I wouldn't have seen it if I hadn't believed it. Exceptional Children, 41, 469-473.

Fraiberg, S. (1977). Insights from the blind. New York: Basic Books.

Fredericks, B. (1985). Parents/families of persons with severe mental retardation. In D. Bricker & J. Filler (Eds.), Several mental retardation: From theory to practice. Reston, VA: Division on Mental Retardation of the Council for Exceptional Children.

Gallagher, J. J. (1990). The family as a focus for intervention. In S. J. Meisels and J. P. Shonkoff (Eds.) Handbook of Early Childhood Intervention, Cambridge Unversity Press: New York.

Gallagher, J. J., Beckman, T., & Cross, A. H. (1983). Families of handicapped children: Sources of stress and its amelioration. Exceptional Children, 50, 10-18.

Garland, C., Swanson, B., Stone, N.W., Woodruff, G. (Eds.). (1981). Early intervention for children with special needs and their families: Findings and recommendations. Seattle, WA: Washington University. (ERIC Document Reproduction Service No. ED 207 278).

Gatling, J., & White, K. R. (1987, April). The involvement of parents as a policy issue in the provision of intervention services for infants and preschoolers. Paper presented at the Society for Research in Child Development Conference, Baltimore, MD.

Glass, G. V (1976). Primary, secondary, and meta-analysis of research. Educational Researcher, 5, 3-8.

Goldstein, D. J., Smith, K. B., Waldrup, E. L., & Inderbitten, H. M. (1987). Comparison of the Woodcock-Johnson Scales of Independent Behavior and Bineland Adaptive Behavior Scales in infant assessment. Journal of Psychoeducational Assessment, 5, 1-6.

Goodman, M., Rothberg, A. D., Houston-McMillan, J. E., Cooper, P. A., Cartwright, J. D., van der Velde, M. A. (1985). Effect of early neurodevelopmental therapy in normal and at-risk survivors of neonatal intensive care. The Lancet, 1327-1331.

Gordon, I. J., Guinagh, B. J., & Jester, R. E. (1977). The Florida parent education infant and toddler programs. In M. C. Day & R. K. Parker (Eds.), The preschool in action (2nd ed.). Boston: Allyn & Bacon.

Gould, S. J. (1983). The mismeasure of man. New York: Norton.

Gowen, J. W., Christy, D. S., & Sparling, J. (1993). Informational needs of parents of young children with special needs. Journal of Early Intervention, 17, 194-210.

Gray, S. W., Ramsey, B. K., & Klaus, R. A. (1982). Form 3 to 20: The early training project. Baltimore, MD: University Park Press.

Greenwood, C. R. (1991). Longitudinal analysis of time, engagement, and achievement in at-risk versus non-risk students. Exceptional Children, 57, 521-535.

Greenwood, C. R., Delquadri, J., & Hall, R. V. (1984). Opportunity to respond and student academic performance. In W. Heward, T. Heron, D. Hill, & J. Trap-Porter (Eds.), Behavior analysis in education (pp. 58-88). Columbus, OH: Charles E. Merrill.

Gresham, F. M., & Elliott, S. N. (1990). Social skills rating system. Circle Pines, MN: American Guidance Service.

Guralnick, M. J., & Bennett, F. C. (Eds.) (1987). The effectiveness of early intervention for at-risk and handicapped children. Orlando, FL: Academic Press.

Hack, M., Caron, B., Rivers, A., & Fanaroff, A. (1983). the very low birth weight infant: The broader spectrum of morbidity during infancy and early childhood. Developmental and Behavioral Pediatrics, 4, 243-249.

Haley, J. (1976). Problem-solving therapy. San Francisco, Jossey-Bass.

Haley, J. (1980). Leaving home. New York: McGraw-Hill.

Halpern, R. (1984). Lack of effects for home-based early intervention? Some possible explanations. American Journal of Orthopsychiatry, 54, 33-42.

Hanline, M. F., & Knowlton, A. (1988). A collaborative model for providing support to parents during their child's transition from infant intervention to preschool special education public schools programs. *Journal of the Division for Early Childhood*, *12*, 116-125.

Hanson, M. J., & Lynch, E. W. (1989). *Early Intervention: Implementing Child and Family Services for Infants and Toddlers Who Are At-risk or Disabled*. Austin, TX: PRO-ED.

Haring, N. G., & Innocenti, M. S. (1989). Managing learning time: Structured teaching during unstructured times. In C. Tingey (Ed.), *Implementing early intervention* (pp. 279-302). Baltimore, MD: Brookes Publishing.

Haskins, R., & Adams, D. (1982). Parent education and public policy: Synthesis and recommendations. In. Haskins, R. (Ed.), *Parent education and public policy*, (pp. 346-370). Norwood, NJ: Ablex Publishing Co.

Harter, S., & Pike, R. (1983). *The pictorial scale of perceived competence and social acceptance for young children*. University of Denver.

Hedrick, D. L., Prather, E. M., & Tobin, A. R. (1984). *Sequenced Inventory of Communication Development*, Seattle, WA: University of Washington Press.

Henry, J. C. (1977). The effect of parent assessment and parent training of preschool mentally retarded children on Piagetian tasks of object permanence and initiation. *Dissertation Abstracts International*, *38*(4-A), 2044.

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research*, *11*, 213-218.

Hopkins, K. D. (1973). Research design and analysis clinic: Preventing the number-one misinterpretation of behavioral research, or how to increase statistical power. *The Journal of Special Education*, *7*, 103-107.

House, J. S., & Kahn, R. L. (1985). Measures and concepts of social support. In S. Cohen, & S. L. Syme (Eds.), *Social support and health*. London: Academic Press.

Hunt, J. M. (1961). *Intelligence and experience*. New York: Ronald Press.

Hynd, G. W., Hartlage, L. C., & Noonan, M. (1984). Intracranial hemorrhage in neonates: Data on cognitive development. *The International Journal of Clinical Neuropsychology*, *6*, 111-114.

Infant Health and Development Program (1990). Enhancing the outcomes of low-birth-weight, premature infants. *Journal of the American Medical Association*, *263*, 3035-3042.

Innocenti, M. S. (1990, May). *Predictive utility of general student engagement in a preschool early intervention setting*. Paper presented at the Association for Behavior Analysis, Nashville, TN.

Innocenti, M. (1991). *Three studies examining the construct of intensity as an intervention variable in early intervention programs for children with disabilities*. Unpublished Doctoral Dissertation, Utah State University, Logan, UT.

Innocenti, M. S., Hollinger, P. D., Escobar, C. M., & White, K. R. (1993). The cost-effectiveness of adding one type of parent involvement to an early intervention program. Early Education and Development, 4(4).

Innocenti, M. S., Huh, K., & Boyce, G. C. (1993, March). A comparative study of the child and family effects of adding a parent involvement program to an existing early intervention program. Poster presentation at the 60th annual meetin of the Society for Research in Child Development, New Orleans, LA.

Innocenti, M. S., Rule, S., & Fiechtel, B. J. (1989). Preparing for transition: A guide for administrators of preschool special education program. Resources in Education, (EC 210 775).

Innocenti, M. S., & White, K. R. (1993). Are more intensive early intervention programs more effective? A review of the literature. Exceptionality, 4, 31-50.

Ireton, H. R., Thwing, E. J. (1972). Minnesota child development inventory. Minneapolis, MN: Behavior Science Systems.

Ireton, H., & Thwig, E. (1974). Manual for the Minnesota Child Development Inventory. Minneapolis, MN: Behavior Science Systems.

Jago, J. L., Jago, A. G., & Hart, M. (1984). An evaluation of the total communication approach for teacing language skills to developmentally delayed preschool children. Education and training of the Mentally Retarded, 175-182.

Jester, R. E., & Guinagh, B. J. (1983). The Gordon Parent Education Infant and Toddler Program. In the Consortium for Longitudinal Studies, As the twig is bent: Lasting effects of preschool programs, (pp. 103-132). Hillsdale, NJ: Erlbaum.

Johnson, N. M., & Chamberlin, H. R. (1983). Early intervention: The state of the art. In American Association of University Affiliated Programs for persons with Developmental Disabilities, Developmental Handicaps: Prevention and Treatment. Washington, DC.

Joseph, I. (1979). Joseph preschool and primary self-concept screening test. Chicago, IL: Stoelting.

Kaiser, A. P., & Fox, J. J. (1986). Behavioral parent training research. In J. J. Gallagher, & P. N. Vietze (Eds.), Families of handicapped persons, (pp. 219-235). Baltimore, MD: Brooks.

Kakalik, J. S., Furry, W. S., Thomas, M. A., & Carney, M. F. (1981). The cost of special education: Summary of study findings. Santa Monica, CA: The Rand Corporation.

Karnes, M. B., Hodgins, A. S., & Teska, J. A. (1969). Investigations of classroom and at-home interventions. Research and development programs on preschool disadvantaged children. Final report, 1. Washington, DC: U.S. Department of Health, Education, and Welfare.

Karnes, M. B., & Lee, R. D. (1978). What research and experience say to the teacher of exceptional children. Early Childhood. Reston, VA: The Council for Exceptional Children.

Klaus, M., & Kennell, J. (1982). Intervention in the premature nursery: Impact on development. Pediatric Clinics of North America, 29, 1263-1273.

Klein, B., van Hasselt, V. B., Trefelner, M., Sandstrom, D. J., Brandt-Snyder, P. (1988). The parent and toddler training project for visually impaired and blind multihandicapped children. *Journal of Visual Impairment and Blindness*, *82*, 59-64.

Knowles, M. S. (1980). *The modern practice of adult education: From pedagogy to andragogy*. Chicago, IL: Follett Publishing Co.

Knowles, M. S. (1984). *Angrgogy in action: Applying modern principles of adult learning*. San Francisco: Jossey-Bass Publishers.

Koegel, R. L., Schreibman, L., Britten, K. R., Burke, J. C., & O'Neill, R. E. (1982). A comparison of parent training to direct child treatment. In. R. L. Koegel, A. Rincover, & A. L. Egel (Eds.), *Educating and understanding autistic children*. San Diego, CA: College Hill.

Koops, B. L., Abman, S. H., Accurso, F. J. (1984). Outpatient management and follow-up of bronchopulmonary dysplasia. *Clinics in Perinatology*, *11*, 101-122.

Lazar, I. (1981). Early intervention is effective. *Education Leadership*, 303-305.

Lazar, I., & Darlington, R. (1982). Lasting effects of early education: A report from the Consortium for Longitudinal Studies. *Monographs of the Society for Research in Child Development*, *47* (Serial No. 195).

Lazar, I., Darlington, R., Murray, Royce, & Snipper, (1982). Lasting effects of early education: A report from the Consortium for Longitudinal Studies. *Monographs of the Society for Research in Child Development*, *47* (Serial No. 195).

Levenstein, P. (1970). Cognitive growth in preschoolers through verbal interaction with mothers. *American Journal of Orthopsychiatry*, *40*, 426-432.

Levin, H. M. (1983). *Cost-effectiveness: A primer*. Beverly Hills, CA: Sage.

Lochman, J. E., & Brown M. V. (1980). Evaluation of dropout clients and of perceived usefulness of a parent education program. *Journal of Community Psychology*, *8*, 132-139.

Lovass, O. I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, *55*, 3-9.

Madge, N., & Marmot, M. (1987). Psychosocial factors and health. *The Quarterly Journal of Social Affairs*, *3*(2), 81-134.

Mahoney, G. (1988). Enhancing the developmental competence of handicapped infants. In K. Marfo (Ed.), *Parent-child interaction and developmental disabilities*, (pp. 203-219). New York: Praeger.

Mahoney, G., Finger, I., & Powell, A. (1985). Relationship of maternal behavior style to the developmen of organically impaired mentally retarded infants. *American Journal of Mental Retardation*, *90*, 296-302.

Mahoney, G., & O'Sullivan, P. (1990). Early intervention practices with families of children with handicaps. *Mental Retardation*, *28*, 169-176.

Mahoney, G., & Powell, A. (1988). Modifying parent-child interaction: Enhancing the development of handicapped children. *Journal of Special Education*, *22*, 82-96.

Marfo, K. (1989). Multi-Pass: A scheme for coding parent-child interaction. Department of Elementary Pscyhology, Memorial Univeristy of Newfoundland, St John's, Newfoundland.

Masi, W. (1979). Supplemental stimulation of the premature infant. In T. M. Field, A. M. Sootek, S. Goldberg, & H. H. Shuman (Eds.), Infants born at risk. New York: Spectrum.

McCormick, M. C. (1985). The contribution of low birth weight to infant mortality and childhood morbidity. New England Journal of Medicine, 312, 82-90.

McCormick, M. C. Shapiro, S., & Starfield, B. H. (1980). Rehospitalization in the first year of life for high-risk survivors. Pediatrics, 66, 991-999.

McCubbin, H. I., Patterson, J. M., & Wilson, L. R. (1983). Family inventory of life events and changes. Family Social Science, University of Minnesota, St. Paul.

McDonnell, A., & Hardman, M. (1988). A synthesis of "best practice" guidelines for early childhood services. Journal of the Division of Early Childhood, 12, 328-341.

McLinden, S. E. (1988). The Comprehensive Evaluation of Family Functioning Scale. Logan, UT: Early Intervention Research Institute.

McLinden, S. (1991). SMA/Lake McHenry. In K. R. White (Ed.), 1985-1990 Final report of the longitudinal studies of the effects and costs of early intervention for handicapped chidlren (pp. 209-241). Logan, UT: Early Intervention Research Institute, Utah State University Affiliated Center for Persons with Disabilities.

Mercer, J. R. (1979). System of multicultural pluralistic assessment: Examiners manual. New York: The Psychological Corporation.

Miller, J. (1981). Assessing language production in children: Experimental procedures. Baltimore, MD: University Park Press.

Minor, S., Minor, J., & Williams, P. (1983). A participant modeling procedure to train parents of developmentally disabled infants. Journal of Psychology, 115, 107-111.

Montgomery Public Schools (1988). A longitudinal study of children in preschool special education programs. Rockville, MD. (ERIC Document Reproduction Service No. EC 222 061)

Moore, M. T., & Steele, D. (1988). The relationship between chapter 1 and special education services for mildly handicapped students: A substudy of the national assessment of Chapter 1. Washington, DC: Decision Resoruces Corporation.

Mott, S. E., Fewell, R. R., Lewis, M., Meisels, S. J., Shonkoff, J. P., & Simeonsson, R. J. (1986). Methods for assessing child and family outcomes in early childhood special education programs: Some views from the field. Topics in Early Childhood Special Education, 6, 1-15.

Msall, M. E., Buck, G. M., Rogers, B. T., & Catanzaro, N. L. (1992). Kindergarten readiness after extreme maturity. American Journal of Diseases in Childhood, 146, 1371-1375.

National Center for Health Statistics (1989). Health, United States, 1988 (DHHS Publication No (PHS 89-1232). Washington, DC: U.S. Government Printing Office.

Newborg, J., Stock, J., Wnek, L., Guidubaldi, J., & Svinicki, J. (1984). Battelle developmental inventory. Allen, TX: DLM Teaching Resources.

Nurcombe, B., Howell, D. C., Raugh, V. A. Teti, D. M., Ruoff, P., & Brennan, J. (1984). An intervention program for mothers of low-birthweight infants: Preliminary results. Journal of the American Academy of Child Psychiatry, 23, 319-325.

O'Brien, R. (1976). Alive...Aware...A person: A developmental model for early childhood services. Rockville, MD: Montgomery County Public Schools.

O'Brodovich, H. M., & Mellins, R. B. (1985). Bronchopulmonary dysplasia. American Review of Respiratory Distress, 132, 694-709.

Olson, M. (1983). A study of the exploratory behavior of legally blind and sighted preschoolers. Exceptional Children, 50, 130-138.

Olson, D. H., Portner, J., & Lavee, Y. (1985). FACES III. Family Social Science, University of Minnesota, St. Paul.

Palmer, F. B., Shapiro, B. K., Wachtel, R. E., Allen, M. C., Hiller, J. E., Harryman, S. E., Mosher, B. S., Meinert, C. L., & Capute, A. J. (1988). The effects of physical therapy on cerebral palsy. The New England Journal of Medicine, 318, 803-808.

Papile, L. A., Burstein, J., Burstein, R., & Koffler, H. (1978). Incidence and evolution of subependymal and intraventricular hemorrhage: A study of infants with birth weights less than 1500 gm. The Journal of Pediatrics, 92, 529-534.

Papile, L. A., Munsick-Bruno, G., & Schaefer, A. (1983). Relationship of cerebral interaventricular hemorrhage and early childhood neurologic handicaps. The Journal of Pediatrics, 103, 273-277.

Parker, M. & Mitchell, D. (1980). Parents as teachers of their handicapped children: A review. University of Waikato, Hamilton, New Zealand: Project PATH. (ERIC Document Reproduction Service No. ED 201 125)

Patterson, G. R. (1979). A performance theory for child family interaction. In R. Caurns (Ed.), Social interaction: Methods, analysis, and evaluation. Hillsdale, NJ: Erlbaum.

Patterson, G. R., & Fleishman, M. (1979). Maintenance of treatment effects: Some considerations concerning family systems and follow-up data. Behavior Therapy, 10, 168-185.

Perils of megavitamin therapy (1987, July). Consumer's Research, 16.

Peterson, N. L. (1987). Early intervention for handicapped and at-risk children: An introduction to early childhood-special education. Denver: Love.

Peterson, N. L., & Cooper, C. S. (1989). Parent education and involvement in early intervention programs for handicapped children: A different perspective on parent needs and the parent-professional relationship. In M. J. Fine (Ed.), The second handbook on parent education: Contemporary perspectives, (pp. 197-234). New York: Academic Press.

Pezzino, J. & Lauritzen, V. (1986). Parents involved in education: A guide for the trainers of parents of young handicapped children. Field-test version published by Utah State University, Logan, UT.

Piper, M. C., Kunos, V. I., Willis, D. M., Mazer, B. L., Ramsay, M., & Silver, K. M. (1986). Early physical therapy effects on the high-risk infant: A randomized controlled trial. Pediatrics, 78, 216-224.

Powell, D. R. (1986). Parent education and support programs. Young Children, 41, 47-53.

Powell, C., & Grantham-McGregor, S. (1989). Home visiting of varying frequency and child development. Pediatrics, 84, 157-164.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. Applied Psychological Measurement, 1, 385-401.

Raju, T. N. K. (1986). An edidemiologic Study of very low and very very low birth weight infants. Clinics of Perinatology, 13, 233-250.

Ramey, C. T., Bryant, D. M. Sparling, J. J., & Wasik, B. H. (1984). A biosocial systems perspective on environmental interventions for low birth weight infants. Clinical Obstetrics and Gynecology, 27(3).

Ramey, C. T., Collier, A. M., Sparling, J. J., Loda, F. A., Campbell, F. A., Ingram, D. L., & Finkelstein, N. W. (1976). The Carolina Abecedarian project: A longitudinal and multidisciplinary approach to the prevention of developmental retardation. In T. D. Tjossem (Ed.), Intervention strategies for high risk infants and young children. Baltimore, MD: University Park Press.

Ramey, C. T., & Haskins, R. (1981). The modification of intelligence through early experience. Intelligence, 5, 5-19.

Ramey, C. T., McPhee, D., & Yeates, K. O. (1982). Preventing developmental retardation: A general systems model. In L. A. Bond, & J. M. Joffe (Eds.), Facilitating infant and early childhood development. London: University Press of New England.

Raugh, V. A., Achenbach, T. M., Nurcombe, B., Howell, C. T., & Teti, D. M. (1988). Minimizing adverse effects of low birthweight: Four year results of an early intervention program. Child Development, 59, 544-553.

Resnick, M. B., Armstrong, S., & Carter, R. L. (1988). Developmental intervention program forh igh-risk premature infants: effects on development and parent-infant interactions. Developmental and Behavioral Pediatrics, 9, 73-78.

Resnick, M., Eyler, F., Nilson, R., Eitzman, D., & Buciarelli, R. (1987). Developmental intervention for low birth weight infants: Improved developmental outcome. Pediatrics, 1, 68-74.

Richardson, D. K., Gray, J. E., McCormick, M. C., Workman, K., & Goldman, D. H. (1993). Score for neonatal acute physiology: A physiologic severity index for neonatal intensive care. Pediatrics, 91, 617-623.

Roberts, R. N., & Wasik, B. H. (1990). Home visiting programs for families with children birth to three: Results of a national survey. Journal of Early Intervention, 14, 274-284.

Rogow, S. (1982). Rhythms and rhymes: Developing communication in very young blind and multi-handicapped children. Child: Care, Health, and Development, 8, 260.

Rosenthal, R. (1976). Experimental effects in behavioral research. New York: Irvington.

Rowland, C. (1984). Preverbal communication of blind infants and their mothers. Journal of Visual Impairment and Blindness, 78, 297-302.

Sameroff, A., & Chandler, L. A. (1975). Transactional models in early social relations. Human Development, 18, 65-79.

Sandall, S. R. (1990). Developmental interventions for biologically at-risk infants at home. Topics in Early Childhood Special Education, 10, 1-13.

Sandow, S., & Clarke, A. D. B. (1978). Home intervention with parents of severely subnormal, pre-school children: An interim report. Children, Health, and Development, 4, 29-34.

Sandow, S., Clarke, A. D. B., Cox, M. V., & Stewart, F. L. (1981). Home intervention with parents of severely subnormal, preschool children: A final report. Child: Care, Health, and Development, 7, 135-144.

Saylor, C., Levkoff, A., & Elksnin, N. (1989) Premature infants with intraventricular hemorrhage: A need for early intervention. Topics in Early Childhood Special Education, 9, 86-98.

Scherzer, A. L., Mike, V., & Ilson, J. (1976). Physical therapy as a determinant of change in the cerebral palsied infant. Pediatrics, 58, 47-52.

Seitz, V., Rosenbaum, L. K., & Apfel, N. H. (1985). Effects of family support intervention: A ten-year follow-up. Child Development, 56, 376-391.

Shearer, D. E., & Shearer, M. S. (1976). The Portage Project: A model for early childhood intervention. In T. E. Tjossem (Ed.), Intervention strategies for high-risk infants and children, (pp. 335-350). Baltimore, MD: University Park Press.

Silberman, R. K., Corn, A. L., & Sowell, V. M. (1989). A profile of teacher educators and the future of their personnel preparation programs for serving visually handicapped children and youth. Journal of Visual Impairment and Blindness, 83, 150-155.

Simeonsson, R. J. (1981). Carolina record of individual behavior. Carolina Institute for Research on Early Education of the Handicapped, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

Simeonsson, R. J., Cooper, D. H., & Scheiner, A. P. (1982). A review and analysis of the effectiveness of early intervention programs. Pediatrics, 69, 635.

Skeels, H. (1965). Effects of adoption of children from institutions. Children, 12, 33-34.

Skeels, H., & Fillmore, E. (1937). The mental development of children from underprivileged homes. Journal of Genetic Psychology, 50, 427-439.

Skeels, H., Updegroff, R., Wellman, B., & Williams, H. (1938). A study of environmental stimulation: An orphanage preschool project. University of Iowa Studies in Child Welfare.

Smith, L., Ulvund, S. E., & Lindemann, R. (in press). Ver low birth weight infatns (< 1501 g) at double risk. Journal of Developmental and Behavioral Pediatrics.

Smith, R. W. (1986). Physically disabled children and parental time use. Journal of Leisure Records, 18, 284-299.

Snyder, K. D., Weeldreyer, J. C., Dunst, C. J., & Cooper, C. S. (1985). Parent self-awareness scale. Morganton, NC: Western Carolina Center.

Song, A. Y., & Jones, S. E. (1980). Wisconsin Behavior Rating Scale. Madison, WI: Central Wisconsin Center for the Developmentally Disabled.

Songs, A., Jones, S., Lippert, J., Metzgen, K., Miller, J., & Borreca, C. (1984). Wisconsin Behaior Rating Scale: Measure of adaptive behaior for the developmental levels of 0 to 3 years. American Journal of Mental Deficiency, 88, 401-410.

Sostek, A. (1992). Prematurity as well as intraventricular hemorrhage influence developmental outcome at 5 years. In S. L. Friedman & M. D. Sigman (Eds.), Psychological development of low birthweight children: Annual advances in applied developmental psychology (Vol. 6). NJ: Ablex Publishing Co.

Sostek, A., Smith, Y., Katz, K., & Grant. E. (1987). Developmental outcome of preterm infants with intraventricular hemorrhage at one and two years of age. Child Development, 58, 779-786.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. Journal of Marriage and the Family, 38, 15-28.

Sparrow, S., Balla, D., & Cicchetti, D. V. (1984). Vineland Adaptive Behavioral Scales--Expanded Form. Circle Pines, MN: American Guidance Service.

Strom, R. (1984). Parent as a teacher inventory. Bensenville, IL: Scholastic Testing Service, Inc.

Switzky, H. N., & Haywood, H. C. (1985). Perspectives on methodological and research issues concerning severely mentally retarded persons. In D. Bricker, & J. Filler (Eds.), Severe mental retardation: From theory to practice. Reston, VA: Division on Mental Retardation of the Council for Exceptional Children.

Tallmadge, G. K. (1977). Ideabook: The Joint Dissemiantion Review Panel. Washington, DC: U.S. Office of Education.

Tarby, T. J., & Volpe, J. J. (1982). Intraventricular hemorrhage in the premature infant. Pediatric Clinics of North American, 29, 1077-1104.

Taylor, C., White, K. R., & Pezzino, J. (1984). Cost effectiveness analysis of full-day versus half-day intervention programs for handicapped preschoolers. *Journal of the Division for Early Childhood*, *9*, 76-85.

Teller, D., Morse, R., Boston, R., & Regal, D. (1974). Visual acuity for vertical and diagnoal gratings in human infants. *Vision Research*, *4*, 433-439.

Thoits, P. (1982). Conceptual, methodological and theoretical problems in studying social support as a buffer against stress. *Journal of Health and Social Behaviour*, *23*, *145-159.*

Thorndike, R. L., Hagon, E. P., & Sattler, J. M. (1986). *Stanford-Binet intelligence scale*. Chicago, IL: Riverside.

Turnbull, A. P., Summers, J. A., & Brotherson, M. J. (1983). *The impact of young handicapped children on families*. Paper presented at NIHR state-of-the-art conference on parents roles in the rehabilitation of handicapped children up to 5 years of age, Washington, DC.

U. S. Department of Labor, Bureau of Labor Statistics (1989). *Employment and earnings*, *36*(1), 219. Washington, DC: Author.

Upshur, C. C. (1991). Mothers' and fathers' ratings of the benefits of early intervention services. *Journal of Early Intervnetion*, *15*(4), 345-357.

Veiel, H. O. F. (1985). Dimensions of social support: A conceptual framework for research. *Social Psychiatry*, *20*, 156-162.

Vitamins: When more is too much (1986, April). *Changing Times*, 45-49.

Vohr, B., & Garcia-Coll, C. (1988). Follow-up studies of high risk low-birthweight infants: Changing trends. In Fitzgerald, Lester, & Yogman (Eds.), *Theory and research in behavioral pediatrics* (pp. 1-65). New York: Plenum Press.

Volpe, J. J. (1981). Neonatal intraventricular hemorrhage. *The New England Journal of Medicine*, *304*, 886-891.

Volpe, J. J. (1987). *Neurology of the newborn*. Philadelphia, PA: Saunders, Co.

Wahler, R. G., Leske, G., & Rogers, E. S. (1979). The insular family: A deviance support system for oppositional children. In L. A. Hamerlynck (Ed.), *Behavioral systems for the developmentally disabled* (Vol. 1). New York: Brunner/Mazel.

Warren, D. H. (1984). *Blindness and early childhood development* (2nd edition, revised). New York: American Foundation for the Blind.

Washington, E. D., & Osborne, J. (1969). The dual kindergarten. In C. Bereita & E. D. Washington (Eds.), *Research and development program of preschool disadvantaged children: Final Report* (pp. 39-54). Washington, DC: United States Department of Health, Education, and Welfare. (ERIC Document Reproduction Service No. ED 036 664)

Weikart, D. P., Bond, J. T., & McNeir, J. T. (1978). *The Ypsilanti Perry Preschool Project: Preschool years and longitudinal results* (Monographs of the High/Scope Educational Research Foundation No. 3). Ypsilanti, MI: High/Scope Press.

White, K. R. (1986). Efficacy of early intervention. Journal of Special Education, 19, 401-416.

White, K. R. (Ed.) (1991). 1985-1991 Final Report of the Longitudinal Studies of the Effects and Costs of Early Intervention with Handicapped Children (contract # 300-85-0173). Logan, UT: Early Intervention Research Institute.

White, K. R., Bush, D., & Casto, G. (1985-86). Learning from previous reviews of early intervention research. The Journal of Special Education, 19, 417-428.

White, K. R., & Casto, G. (1985). An integrative review of early intervention efficacy studies with at-risk children: Implications for the handicapped. Analysis and Intervention in Developmental Disabilities, 5, 7-31.

White, K. R., Mott, S. E., & Barnett, W. S. (1987). 1986-87 Annual report of the longitudinal studies of the effects and costs of early intervention for handicapped children. Logan, UT: Early Intervention Research Institute. (ERIC Clearinghouse on Handicapped and Gifted Youth #EC 202 089)

White, K. R., & Pezzino, J. (1986). Ethical, practical, and scientific considerations of randomized experiments in early childhood education. Topics in Early Childhood Special Education, 6(3), 100-116.

White, K. R., Taylor, M., & Moss, V. (in press). Does research support claims about the benefits of involving parents in early intervention programs? Review of Educational Research.

Williamson, W. D., Desmond, M. M., Wilson, G. S., Andrew, L., & Garcia-Prats, J. A. (1982). Early developmental outcome of low birthweight infants surviving neonatal intraventricular hemorrhage. The Journal of Perinatal Medicine, 10, 34-41.

Woodcock, R. W., & Johnson, M. B. (1989). Wooodcock-Johnson tests of achievement. Allen, TX: DLM Teaching Resources.

Zeitlin, S., & Williamson, G. G. (1988). Developing family resources for adaptive coping. Journal of the Division for Early Childhood, 12, 137-146.

Zigler, E., & Balla, D. (1982). Selecting outcome variables in evaluations of early childhood special education programs. Topics in Early Childhood Special Education, 1, 11-22.

Zigler, E., Taussig. C., & Black, K. (1992). Early childhood intervention: A promising preventative for juvenile delinquency. American Psychologist, 47, 997-1006.

Zimmerman, I. L., Steiner, V. G., & Evatt, E. P. (1969). Preschool language scale. Columbus, OH: Merrill Publishing Co.